STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(F 000)	INITIAL COMMENTS	(F 000)	Disclaimer for Plan of Correction	

A revisit was completed on May 13, 2014, and May 14, 2014, following acceptance of an Allegation of Compliance submitted May 6, 2014, to remove the Immediate Jeopardy for F157 level "J", F224 level "K", F309 level "K", F281 level "L", F333 level "L", F425 level "L", F490 level "L", F501 level "L", F520 level "L."

The revisit revealed the corrective actions implemented May 7, 2014, removed the Immediate Jeopardy, but non-compliance continues at a "D" level Scope and Severity for F 157, an "E" level Scope and Severity for F 224 and F 309, and an "F" Scope and Severity level for F 281, F 333, F425, F 490, F 501, and F 520, for the facility's monitoring the effectiveness of corrective actions in order to ensure sustained compliance and evaluation of the processes by the Quality Assurance Committee.

A complaint investigation (#33563 and #33346), was conducted from April 14, 2014, through April 23, 2014, and a revisit survey (for the Recertification survey February 4, 2014) was conducted from April 14, 2014, through April 24, 2014. The facility was found to have continued noncompliance for failure to follow physician's orders, and for having significant medication errors. Deficiencies were cited related to complaint investigation #33563.

Based on findings from the revisit and the complaint investigation conducted April 14-24, 2014, the facility was cited an Immediate Jeopardy, (a situation in which the provider's

Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by Christian Care Center of Rutherford County of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. Christian Care Center of Rutherford County files this Plan of Correction solely because it is required to do so for continued state licensure as a health care provider and/or for participation in the Medicare/Medicaid program. The facility does not admit that any deficiency existed prior to, at the time of, or after the survey. The facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal and any other applicable legal or administrative proceedings. This Plan of Correction should not be taken as establishing any standard of care, and the facility submits that the actions taken by or in response to the survey findings far exceed the standard of care. This document is not intended to waive any defense, legal or equitable, in administrative, civil or criminal proceedings.

(X6) SIGNATURE	TITLE	(X7) DATE
Gary Parker	Interim Administrator	6/9/14

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 000}	Continued From page 1	{F 000}		

Jeopardy, (a situation in which the provider's noncompliance had caused, or is likely to cause serious injury, harm, impairment, or death), and Substandard Quality of Care. The facility failed to ensure a systematic process was in place for medication reconciliation for hospital discharge orders with facility admission orders for resident #3, resulting in resident #3's neglect. The facility failed to reconcile hospital discharge orders with facility admission orders and failed to follow-up on medication reconciliation audits resulting in medication errors for resident #19, and failed to monitor blood sugars and insulin administration for resident #14. The facility failed to follow physician orders for eleven residents (#3, #19, #14, #1, #10, #13, #24, #26, #28, #29, #30) of thirty-one residents reviewed. The facility's systemic failure to ensure staff followed professional standards of practice in order to reconcile physician orders for accuracy and ensure medications were administered as ordered; failure to follow-up on the facility's audits of medication reconciliation errors, and failure to monitor blood sugars and insulin has the potential of Immediate Jeopardy for any resident who receives medication.

The facility was cited an Immediate jeopardy at F157-J, F224-K, F281-K, F-309-K, F333- L, F425-L, F490-L, F501-L, and F520-L.

The Administrator, Regional Administrator Consultant, Assistant Director of Nursing, Nurse Consultant #1/Acting Director of Nursing, Nurse Consultant #2, Nurse Consultant #3, Vice-President of Client Operations, and Medical Director #1 were informed of the Immediate Jeopardy on April 24, 2014, at 10:55 a.m., in the Conference Room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445602	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(F 000) Continued From page 2

(F 000)

An partial extended survey was conducted on April 24, 2014.

The Immediate Jeopardy was effective March 14, 2014, and was ongoing.

Substandard Quality of Care was cited at F224-K, F309-K, and F333-L.

(F 157) 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)
SS=D

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

(F 157) F 157

Christian Care Center of Rutherford County believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:

Corrective Actions for Targeted Residents

The Dialysis Physician treating Resident #19 was notified of medication errors involving Crestor, PhosLo, Mirtazapine, and Protonix by the Director of Nursing on 4/25/14.

Identification of Other Residents with Potential to be Affected

Current residents have the potential to be affected by this practice. The facility-Nursing Staff will notify residents' treating physician(s), as well as the residents' responsible party, on the day of discovery, of any medication errors experienced by facility-residents. Nursing Staff will also document any medication errors on the 24-hour Nursing Report to communicate medication error

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

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(F 157) Continued From page 3

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, review of Medication Reviews/3 Month Reviews, review of facility policy, and interview, the facility failed to notify the physician of medication errors for one resident (#19) of thirty-one sampled residents.

The facility provided an acceptable Allegation of Compliance on May 8, 2014, and a revisit on May 13, 2014, and May 14, 2014, revealed the corrective actions implemented on May 2, 2014, removed the immediacy of the jeopardy.

Noncompliance for F-157 continues at a "D" level citation for the facility's monitoring the effectiveness of corrective actions in order to ensure sustained compliance and evaluation of the processes by the Quality Assurance Committee.

The findings included:

Resident #19 was admitted to the facility on February 26, 2014, and readmitted to the facility on March 27, 2014, with diagnoses including Acute Edema, Hypertension, Chronic Kidney Disease, Heart Disease, End Stage Renal Disease, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Parkinson's Disease, and Dementia.

Medical record review revealed Resident #19

(F 157)

issues with the Administrative Staff. A 100% audit of active residents' admission/re-admission orders from the facility-pharmacy matching the discharge orders from the previous provider, ensuring all pages were faxed to the pharmacy and reconciled correctly onto the MARs, was conducted by the DON and Nurse Consultant beginning 4/18/14 and completed on 4/22/14. The results of these admission/re-admission order audits and the actions taken by the DON and Nurse Consultant are as follows: Orders not transcribed correctly onto the MAR affected nine residents. These residents' medications were reconciled correctly onto the MAR by the Nurse Consultant on 4/22/14. Omission of medication administration doses affected two residents. MD and family were notified of errors on 4/22/14 by the Nurse Consultant. Nursing education of licensed staff by the DON occurred on 4/24/14 regarding these errors. Also, on 4/25/14, the DON re-wrote clarification orders for all resident charts cited for this issue by matching current orders to current MARs to ensure Physician's orders are followed and medication reconciliation is correct. Remaining residents' medications were reconciled during the monthly MAR change-over procedure by Nursing Staff on 4/28/14. This MAR change-over was double-checked for accuracy by the Nursing Consultant on 4/28/14 and 4/29/14 to ensure accurate resident medication reconciliation occurred. Beginning 4/22/14, the new procedure of two nurses reconciling discharge orders from the hospital/previous provider with the physician's orders/MARs sent by the facility-pharmacy was initiated. The Admitting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	446632	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

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(F 157) Continued From page 4

received Dialysis treatment three days per week for Chronic Kidney Disease. Medical record review of the hospital Discharge Med (Medical) Rec (Record) form dated March 27, 2014, revealed no order for Phoslo (Calcium Acetate) 667 mg (milligrams), a medication used to bind with phosphorus in the body to decrease the level of phosphorus in the blood. Continued review also revealed no order for Crestor 20 mg (an antistatin medication used to lower cholesterol). Further review of the Discharge Med Rec form revealed orders for Mirtazapine 7.5 mg (an antidepressant medication) and Protonix 40 mg (a stomach medication used to control acid in the stomach).

Medical record review of Physician's Orders (Recapitulation orders) dated March 27, 2014, through March 31, 2014, revealed a medication order for "...Calc (calcium) Acetate Cap 667 mg 1 capsule PO (by mouth) with meals...For PhosLo..." Continued review of Physician's Orders revealed a medication order for "...Crestor tab (tablet) 20 mg 1 tablet PO at bedtime..." Further review of the Physician's Orders for March 27, 2014, through March 31, 2014, revealed no medication orders for Mirtazapine (Remeron) or Protonix.

Medical record review of the Medication Administration Records (MARS) dated March 27, 2014, through March 31, 2014, revealed the resident received both Calcium Acetate and Crestor March 28, 2014, through March 31, 2014. Continued review of the MAR revealed the resident was not administered Mirtazapine or Protonix.

Medical record review of the April 1, 2014,

(F 157) Nurse will place a telephone call to the newly-admitted resident's attending physician to review/accept orders. Any clarification orders given by the admitting physician will be taken by the admitting nurse as telephone orders and faxed to the pharmacy with the admission/re-admission orders brought by EMS/accompanied with the resident.
Beginning 4/18/14, the new procedure of the DON reconciling all admission/re-admission orders daily was initiated. This audit of reconciliation of admission/re-admission orders will be completed by the Nursing Supervisor on weekends or in the absence of the DON.

Systematic Changes

Mandatory in-services were conducted for licensed staff by the Nurse Consultants on 4/28/14 and repeated on 4/29/14 in three sessions, regarding the need to notify residents' treating physicians, in addition to the Attending Physician, as well as the resident's family/responsible party, of medication errors experienced by the residents. This in-service for licensed staff by the Nurse Consultants also addressed the need to pull the residents' charts as a guide for monthly MAR change-over, to ensure all current orders are noted, and not just comparing new month/s MARs with the previous month's MARs.
Licensed nurses were also educated by the Nurse Consultants to document any medication errors onto the 24-hour Nursing Report to communicate medication error issues with the Administrative Staff. This

(X1) STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X2) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X3) MULTIPLE CONSTRUCTION	(X4) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

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{F 157} Continued From page 5

through April 31, 2014. Physician's Orders and MARS revealed the pharmacy had included the orders for Mirtazapine and Protonix which had originally been omitted from the resident's readmission to the facility on March 27, 2014. Continued review of the Physician's Orders and MARS for April 2014, revealed nursing discontinued these medications during reconciliation of the March 27, 2014, Physician's Orders with the April, 2014 Physician's Orders provided by the pharmacy. Further review of the April Physician's Orders and MARS revealed no orders for the Calcium Acetate or Crestor (which had been omitted by pharmacy from the original hospital discharge orders and Physician's Orders March 27, 2014). Further review of the April Physician's Orders and MARS revealed nursing changed the orders to match the March 27, 2014 Physician's orders and MARS which had been added by the pharmacy in error. Therefore resident #19 continued to be administered 2 medications without an order (Calcium Acetate and Crestor), and failed to be administered 2 medications (Mirtazapine and Protonix) which had been ordered by the discharging hospital from March 27, 2014, through April 17, 2014.

Medical record review of Medication Reviews 3 Month Review dated April 4, 2014, revealed "... (Facility) Medication Reviews 3 Month Review...3-27-14 re-admit...pharmacy omitted...Protonix...Remeron (Mirtazapine), the pharmacy also added Crestor and Phoslo (Calcium Acetate) without an order. This was not caught by nursing. The April POS (Physician's orders) from the pharmacy were correct, however when the nurse checked the POS (Physician's orders) (the nurse) changed all the orders to match March's MAR..." Further review of facility

{F 157} mandatory in-service for licensed staff on 4/28/14 and 4/29/14 by Nurse Consultants also informed the nurses that after reviewing the Standing Orders with the Medical Director, there is no longer a facility protocol for sliding scale insulin administration – effective 4/29/14. Per the Medical Director's approval, sliding scale insulin administration will follow the physician's discharge orders from the hospital/previous provider. Pharmacy was notified of this revision for Standing Orders on 4/29/14. Nurses were also educated that only hospital/previous provider's discharge orders brought by EMS, or accompanied with the resident if not transported by EMS, are acceptable. All facility licensed nurses on staff attended one of these in-services. Newly-hired nurses and agency nurses will be educated by the DON, prior to reporting to the floor for the first time, of the need to notify residents' treating physicians – not just the Attending Physician, and resident's responsible party of medication errors experienced by the resident, documentation of errors onto the 24-hour Nursing Report, and pulling charts for current orders during monthly MAR change-over.

Monitoring

A monthly audit of the 24-hour Nursing Reports, Medication Error Reports, and any medication-related issues arising from monthly MAR change-over will be conducted by the DON to ensure residents' treating physician(s) are notified immediately, should a medication error occur. Results of these medication error audits will be presented by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

{F 157} Continued From page 6

documentation revealed the Medication Reviews 3 Month Review was sent by email from Nurse Consultant #1 to the Director of Nursing (DON) and Administrator on April 4, 2014.

Interview with the DON and Nurse Consultant #1 on April 17, 2014, at 2:55 p.m., in the Conference Room, confirmed the resident's March 2014, and April 2014, Physician's orders and MARs were incorrect. Continued interview confirmed the resident continued to receive discontinued medications, PhosLo (Calcium Acetate) and Crestor without a physician's order, and confirmed the resident did not receive ordered medications Mirtazapine and Protonix from March 27, 2014, until April 17, 2014. Further interview confirmed both the DON and Nurse Consultant #1 became aware the resident was receiving medications that were not ordered, and became aware the resident was not receiving ordered medications on April 4, 2014, and confirmed both had neglected to correct the medication errors, and the resident continued to receive Calcium Acetate and Crestor without physician orders, and did not receive ordered medications, Mirtazapine and Protonix, through April 17, 2014.

Interview with Nurse Consultant #1 on April 24, 2014, at 9:10 a.m., in the Conference Room, confirmed neither the Nurse Consultant or DON had contacted the resident's Dialysis Physician to inform the physician of the medication errors.

Interview with the Dialysis Physician on April 24, 2014, at 2:20 p.m., by phone, confirmed the physician had not been contacted by the facility regarding the resident's medication errors.

Validation of the Credible Allegation of

{F 157} the DON to the monthly Performance Improvement Committee for review and recommendations until desired threshold of 100% has been met for three consecutive months, then quarterly. A Performance Improvement Committee meeting, consisting of the Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Pharmacy Consultant, Quality Assurance Nurse, and MDS Nurses was conducted on 5/22/14, and results of the above audits were found to be in continued compliance. The audits will continue to be completed monthly for three months as a recommendation from the Performance Improvement Committee and will continue to be reviewed monthly by the Performance Improvement Committee for recommendations regarding monitoring frequency, adjustments to monitoring, and/or system changes. The Administrator and DON will follow up on recommendations from the Performance Improvement Committee to assure continued compliance. The monthly Performance Improvement Committee consists of the Administrator, Medical Director, Business Office Manager, Director of Nursing, Assistant Director of Nursing, Human Resources Clerk, Clinical Records Clerk, Marketing/Admissions Director, MDS Coordinator, Assessment Nurse, Director of Activities, Director of Dietary, Director of Housekeeping/Laundry, Maintenance Director, Director of Social Services, Therapy Manager, Consultant Pharmacist, and Line Staff Nurse. 5/22/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 157}	Continued From page 7	{F 157}		

Compliance was accomplished on-site on May 13, 2014, and May 14, 2014, through medical record reviews, review of facility documents, and interviews with Nursing and Administrative Staff.

Medical record review of Resident #19's nursing notes dated April 25, 2014, revealed the Interim Director of Nursing, notified the dialysis physician and the resident's responsible party of the medication errors.

Medical record review of resident #33 revealed the resident was readmitted to the facility on May 8, 2014. Continued review of the physician orders dated May 8, 2014, revealed the orders has been verified with the physician and signed by two licensed nurses. Medical record review of the Medication Administration Record from May 8-13, 2014, revealed the resident received medications as ordered.

The facility provided evidence of audits of reconciliation of admission/re-admission orders, in-service training for all nursing staff related to physician notification of medication errors, admission/readmission physician order and medication reconciliation, medication omissions, blood glucose monitoring and shift to shift audits of accu-checks and sliding scale insulin, sliding scale insulin orders, and physician standing orders, and the pharmacy procedure for medication orders.

The facility provided documentation of an emergency Performance Improvement Meeting held on April 28, 2014, to discuss the new admission/readmission medication reconciliation process, pharmacy process, and physician notification process and establish a plan to

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(F 157) Continued From page 8

ensure physician notification for clarification of medication orders and medication errors.

Interviews with Nursing Staff on all shifts May 13-14, 2014, throughout the facility, revealed the nursing staff had been in-serviced on the protocol for new admission/readmission medication order reconciliation, pharmacy protocol, medication errors, and physician standing orders.

The facility will remain out of compliance at a Scope and Severity level "D" a deficient practice that constitutes no actual harm with potential for more than minimal harm, that is not immediate Jeopardy until it provides an acceptable plan of correction and corrections are verified on-site..

(F 224) SS=E 483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, review of a facility investigation, and interview the facility failed to ensure one resident (#3) received ordered medications for 15 days following a hospital stay, resulting in rehospitalization in critical condition, of thirty-one residents reviewed. The facility's failure to administer prescribed medications resulted in neglect. The facility's

(F 157)

(F 224) F 224

Christian Care Center of Rutherford County believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:

Corrective Actions for Targeted Residents

Resident #3 was transferred to acute care on 3/29/14. Resident #3 returned to the facility on 3/31/14. Resident #3's medications were reconciled from the previous provider accurately on 3/31/14 by the Director of Nursing. Resident #3 was discharged from the facility on 4/1/14.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445592	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 224} Continued From page 9

neglect of the resident placed resident #3 in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death to a resident). The facility's systemic failure to ensure post-hospital discharge orders were reconciled with facility admission orders to ensure all ordered medications are provided in accordance with physician's orders was likely to place any resident admitted/re-admitted from the hospital in Immediate Jeopardy.

The Administrator, Regional Administrator Consultant, Assistant Director of Nursing, Nurse Consultant #1/Acting Director of Nursing, Nurse Consultant #2, Nurse Consultant #3, Vice-President of Client Operations, and Medical Director #1 were informed of the Immediate Jeopardy on April 24, 2014, at 10:55 a.m., in the Conference Room.

The Immediate Jeopardy was effective March 14, 2014, and was ongoing.

An extended survey was conducted on April 24, 2014.

The facility provided an acceptable Allegation of Compliance on May 8, 2014, and a revisit on May 13, 2014, and May 14, 2014, revealed the corrective actions implemented on May 2, 2014, removed the Immediacy of the Jeopardy.

Noncompliance for F224 continues at "E" level citation for the facility's monitoring the effectiveness of corrective actions in order to ensure sustained compliance and evaluation of the processes by the Quality Assurance

{F 224} Identification of Other Residents with Potential to be Affected

Residents newly-admitted and re-admitted to the facility have a potential to be affected by this practice. A 100% audit of active residents' admission/re-admission orders from the facility-pharmacy matching the discharge orders from the previous provider, ensuring all pages were faxed to the pharmacy and reconciled correctly onto the MARs, was conducted by the DON and Nurse Consultant beginning on 4/18/14 and completed on 4/22/14. The results of these admission/re-admission order audits and the actions taken by the DON and Nurse Consultant are as follows: Orders not transcribed correctly onto the MAR affected nine residents. These residents' medications were reconciled correctly onto the MAR by the Nurse Consultant on 4/22/14. Omission of medication administration doses affected two residents. MD and family were notified of errors on 4/22/14 by the Nurse Consultant. Nursing education by the DON for licensed staff regarding these errors occurred on 4/22/14. Beginning 4/22/14, the new procedure was initiated of two nurses reconciling discharge orders from the hospital/previous provider with the physician's orders/MARs sent by the facility-pharmacy with both nurses' signatures on the hospital discharge orders and the MAR sent by the facility-pharmacy. The Admitting Nurse will place a telephone call to the newly-admitted resident's attending physician to review, adjust, and accept admission orders. Any clarification orders given by the admitting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

{F 224} Continued From page 10
Committee.

The findings included:

Resident #3 was admitted to the facility on December 26, 2012, and readmitted to the facility on March 14, 2014, with diagnoses including Respiratory Failure, Chronic Atrial Fibrillation, Sinonal Node Dysfunction, Pneumonia, Chronic Obstructive Pulmonary Disease, Hypertension, and Cerebral Vascular Accident.

Medical record review of the hospital Discharge Med (Medication) Rec (Reconciliation) form dated March 14, 2014, revealed the hospital Discharge Med Rec form contained a total of 6 pages of medications ordered for the resident upon discharge from the hospital and readmission to the facility. Continued review revealed the Discharge Med Rec form for pages 1 and 2 included physician's orders for the resident to continue the following medications on readmission to the facility : Coumadin (blood thinner) 2.5 mg (milligrams) and 1 mg daily for a total of 3.5 mg at 4:00 p.m., Lipitor (statin drug for cholesterol management) 10 mg at bedtime, Coreg (heart medication to regulate heart rate) 25 mg twice per day, Digoxin (heart medication to slow heart rate and control rhythm) 0.125 mg once per day, Cardizem (heart medication to control heart rate and blood pressure) 120 mg once per day, and Lisinopril (medication to control high blood pressure) 10 mg once per day.

Medical record review of Physician's Orders (recapitulation orders) for March 14, 2014, through March 31, 2014, revealed no orders for the following medications: Coumadin, Lipitor, Coreg, Digoxin, Cardizem, or Lisinopril.

{F 224} physician will be taken by the Admitting Nurse as telephone orders and faxed to the pharmacy with the admission/re-admission orders brought by the EMS/accompanied with resident. Upon investigation, it was discovered the root cause of this issue was that more than one set of admission/ re-admission orders from the previous provider were being faxed to the pharmacy, and in this case, not all pages of admission orders were faxed to the pharmacy. Beginning 4/18/14, only one set of admission/ re-admission orders, brought by EMS/ accompanied with resident, will be faxed to the pharmacy to avoid this confusion. Beginning 4/22/14, the new procedure was initiated of the Consultant Pharmacist conducting a daily audit, on-site at the facility, of hospital/previous provider discharge orders to ensure accurate medication reconciliation from the previous provider was received by the pharmacy, and that all pages of admission/re-admission orders were received by the pharmacy. On-call pharmacist will conduct this audit, on-site at the facility, of medication reconciliation of new admissions/re-admissions on the weekends. This daily audit of admission/re-admission orders by the pharmacist will be on-going until desired threshold of 100% is met for three consecutive months; then quarterly. Also, on 4/25/14, the DON re-wrote clarification orders for all resident charts cited for this issue by matching current orders to current MARs to ensure physician's orders are followed and medication reconciliation is correct. Remaining residents' medications were reconciled during the monthly MAR change-

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

(F 224) Continued From page 11

Medical record review of the Medication Record (form used to document medication administration: MAR) dated March 14, 2014 through March 31, 2014, revealed two pages of medications, neither of which included the Coumadin, Lipitor, Coreg, Digoxin, Cardizem, and Lisinopril.

Medical record review of a nurse's note dated March 30, 2014, revealed, "...Late entry for 3/28/14. At approx. (approximately) 3 p.m. this nurse was called to resident room to assess resident. Resident in bed with eyes closed, shaking et (and) c/o (complained of) being cold. Resident alert et responsive. Vital signs T (temperature) 100.8 orally, P (pulse) 138 (normal range 60-100), R (respirations) 27, B/P (blood pressure) 156/92, O2 (oxygen) 78 % (percent) via (by) nc (nasal cannula) at 3 LPM (liters per minute). This nurse instructed patient to breathe in through nose et out through mouth. O2 increased to 83%. Nurse applied a non-rebreather oxygen mask et O2 increased to 86-92% fluctuating. Nurse notified MD (medical doctor) of pt (patient) status et N/O (new order) to send to ER (emergency room) for eval (evaluation) et tx (treatment)..." Continued review revealed, "...late entry for 3/29/14 5 pm. ER staff called et stated they needed a copy of resident's MAR. This nurse faxed MAR to number provided while on phone inquiring about resident's status. No new diagnosis from hospital at this time. This nurse was informed that diagnostic testing was still being performed..."

Medical record review of a nurse's note dated April 8, 2014, timed 2:49 p.m., and signed by the Director of Nursing (DON) revealed, "...Upon

(F 224) over procedure by Nursing Staff on 4/28/14. This MAR change-over was double-checked for accuracy by the Nurse Consultant on 4/28/14 and 4/29/14 to ensure accurate resident medication reconciliation occurred.

Systematic Changes

On 4/18/14, the Director of Nursing initiated in-services for licensed staff regarding the new Medication Reconciliation Procedure of two nurses reconciling discharge orders from the hospital/previous provider with the physician's orders/MARs sent by the facility-pharmacy with both nurses' signatures on both the hospital discharge orders and the facility-pharmacy MARs. In-service also included the need of the admitting nurse notifying and reviewing admission orders with the resident's attending physician for approval. In-service also included faxing to the pharmacy only one set of orders brought by EMS or accompanied with the resident. This education was ongoing by the DON until all nurses were educated, with 100% of nurses in-serviced by 4/29/14. Beginning 4/18/14, the new procedure of the DON reconciling all admission/re-admission orders daily was initiated. This audit of reconciliation of admission/re-admission orders will be completed by the Nursing Supervisor on weekends or in the absence of the DON. Newly-hired nurses and agency nurses will be educated by the DON prior to working on the floor, of the new Medication Reconciliation Procedure of two nurses verifying hospital/ previous provider discharge orders with orders sent by the facility-pharmacy, verifying

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

{F 224} Continued From page 12

chart review it is noted on the late entry dated 3-30-14 @ (at) 730 a.m., (the note is for 3-28-14) the date for the late entry is incorrect and is actually for 3-29-14 which is when this resident was transferred to the ER for further eval and treatment..."

Medical record review of Emergency Room Provider Report dated March 29, 2014, revealed the resident was evaluated in the emergency room. Continued review of the Emergency Room Provider Report revealed the resident had complained of shortness of breath and "...pt recently diagnosed with pneumonia...noted to be hypoxic with O2 sats (saturation, a measure of the oxygen level in the blood) in the 70's (normal range 90-100). Further review revealed the resident's vital signs were documented as blood pressure 150/50, temperature 100.3, pulse 67, and respirations 20 at 4:06 p.m. Continued review revealed, "...Cardiovascular: normal heart sounds, tachycardia (heart rate over 100), irregularly irregular..." Further review revealed the resident's vital signs were documented at 5:58 p.m. "...b/p 131/80, pulse 154, resp (respirations) 26, and temp 100.3..."

Medical record review of emergency room lab report dated March 29, 2014, revealed the resident's level of the Digoxin medication was reported as "...< (less than) 0.2 L (low)..." Continued review of the emergency room report revealed the resident had an Electrocardiogram (EKG, diagnostic test to evaluate heart rate, rhythm, and electrical pulses). Further review revealed the results of the heart monitoring test was "...A-Fib (Atrial Fibrillation) with RVR (rapid ventricular response) ..." indicating the resident's heart rate and rhythm were abnormal. Continued

{F 224} admission orders with the attending physician, and faxing only the set of orders to the pharmacy brought by EMS/accompanied with the resident. On 4/1/14, Pharmacy Personnel were in-serviced by the Regional Director regarding verifying all numbered pages of admission/re-admission orders and calling the facility to verify number of pages faxed. On 4/15/14, Pharmacy Personnel were in-serviced by the Regional Director to reconcile all orders received from the facility against the hard copy chart orders as a final review. Beginning 4/25/14, the new procedure was initiated of the pharmacy staff at Pharmacy Office #1, home office, assuming the function of order entry to ensure initial medication reconciliation accuracy. The pharmacist at Pharmacy Office #2 will be the second check once the order is filled. Beginning 4/25/14, all new orders, including admission/re-admission orders, will be reviewed by four pharmacy staff by the following procedure:

- Order entry will be performed by pharmacy technician at Pharmacy Office #1.
- Order entry/clinical review for accuracy will be conducted by the pharmacist at Office #1.
- Packaging of product will be performed by the pharmacy technician at Pharmacy Office #2.
- Final review of product and medication orders will be performed by the pharmacist at Pharmacy Office #2.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

{F 224} Continued From page 13

review revealed, "...Clinical Impression: Primary Impression: Pneumonia...Secondary Impressions: AFib, COPD (Chronic Obstructive Pulmonary Disease)..." Further review revealed the resident was admitted to the hospital for further treatment.

Medical record review of Consulting Physician #1's note dated March 29, 2014, revealed the resident was seen by a consulting physician in the hospital. Review of the record revealed, "...Reason for Consultation: Atrial fibrillation..." Further review revealed the resident "...was found to be in atrial fibrillation with a ventricular rate around 170...(resident) has history of chronic atrial fibrillation, chronic heart failure, and had a stroke in September 2012...Currently (resident) is on long term oral anticoagulation (Coumadin)..." Further review of Consulting Physician #1's note revealed, "...Diagnostic Studies: (Resident's) EKG shows atrial fibrillation with a ventricular rate around 185, low voltage, and poor R-wave progression..." Continued review of the consultation note revealed, "...Impression: 1. Atrial fibrillation 2. Acute...chronic heart failure..."

Medical record review of Consulting Physician #2's note dated March 29, 2014, revealed, "...Assessment and Plan: 1. Atrial fibrillation with rapid ventricular response. Continue Cardizem drip initiated in the emergency room...2. Pneumonia...5. Subtherapeutic digoxin level. We will load the patient with digoxin...and repeat level in the morning hours with further orders to follow..."

Medical record review of Hospitalist Physician's Progress Note dated March 30, 2014, revealed, "...Subjective: The patient was noted to have

{F 224} Due to Pharmacy Offices #1 and #2 being on the same computer system, this new pharmacy procedure will not impede nor slow down medication and MAR delivery to the facility. Pharmacy Office #2's pharmacy technicians and pharmacists were educated on 4/29/14 by the Vice President/Clinical Director of Pharmacy Services in person regarding the new procedure of Pharmacy Office #1 assuming the function of order entry and the procedure of orders being reviewed by four pharmacy staff, from both offices, to ensure accurate medication reconciliation from previous provider. 100% of pharmacy technicians and pharmacists were present for this in-service. No agency staff is used by pharmacy #2. Pharmacy #1's pharmacy technicians and pharmacists were educated on 4/25/14 by the Vice President/Clinical Director regarding the new procedure of office #1 assuming all order entries and the procedure of orders being reviewed by four pharmacy staff from both offices. This in-service was repeated by the Pharmacy Operations Manager on 4/29/14; this ensured 100% pharmacy technicians and pharmacists were educated. Newly-hired pharmacy technicians and pharmacists will be educated during their orientation period by the Pharmacy Operations Manager regarding new order entry system, new facility cover sheets for faxing admission/re-admission orders to the pharmacy, and on-site daily audits of admission/re-admission for medication reconciliation accuracy. No agency staff is used by pharmacy #1. Beginning 4/28/14, the pharmacy will provide the facility with a cover sheet for admission/

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

(F 224) Continued From page 14

persistent atrial fibrillation with rapid ventricular response despite Cardizem drip. (Resident) was also noted to have hypoxia (a decreased level of oxygen in the blood)...The patient was also note (noted) to have some decreased responsiveness and (resident) was...transferred to the intensive care unit (ICU)..." Continued review of the physician's progress note revealed, "...Assessment and Plan: The patient is a 59 year old (resident) admitted to the hospital with community acquired pneumonia and atrial fibrillation with rapid ventricular response, pulmonary edema due to acute congestive heart failure exacerbation...Plan: 1. Atrial fibrillation with rapid ventricular response. Heart rate is improving. Continue Cardizem..."

Medical record review of Consulting Physician #3's note dated March 30, 2014, revealed, "... (Resident) also has atrial fibrillation with rapid ventricular rate. (Resident) was transferred to ICU this morning because of hypoxia and also because of persistent atrial fibrillation with rapid rate..." Continued review revealed, "...Impression: 1...Acute respiratory failure 2. Pneumonia 3. Congestive Heart Failure 4. Atrial fibrillation...Recommendations: 1. Agree with transfer to intensive care unit...7. Continue care in the ICU, critically ill..."

Medical record review of the hospital Discharge Summary by Hospitalist Physician dated March 31, 2014, revealed, "...Hospital course: The patient was admitted and started on Cardizem drip...The patient did have a subtherapeutic digoxin level and the patient was loaded with digoxin. The patient was noted to have persistent atrial fibrillation with rapid ventricular response despite the Cardizem drip...The patient was

(F 224) re-admission orders that will consist of a bar code that will move these orders to an "as soon as possible" status for the pharmacy. This cover sheet will also consist of nurse contact number for any clarification issues and number of pages faxed to the pharmacy. The Vice President/Clinical Director of Pharmacy Services conducted mandatory in-services for facility licensed staff on 4/28/14 and 4/29/14 regarding utilization of the new Fax Cover Sheets for Admissions Office, new Fax Cover Sheets for nurses to utilize for admission/re-admissions, and tips for writing and sending medication orders. 100% of facility-licensed staff attended one of these in-services. Prior to reporting to the floor for the first time, newly-hired and agency licensed staff will be in-serviced by the DON regarding the new pharmacy cover sheet to be utilized with admission/re-admission orders to place these orders in a "priority" status for the pharmacy.

Monitoring

Beginning 4/24/14, daily audits of admission/ re-admission orders will be conducted by the DON to ensure that all pages of the orders were faxed to the pharmacy and that accurate medication reconciliation from the hospital/ previous provider onto the MAR occurred with two nurses verifying and initialing both forms. Nursing Supervisor will audit admission/re-admission orders on the weekends. Noncompliance issues that may arise from this audit will be reported to the Administrator and addressed by the DON with nursing education and disciplinary action as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	282 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

{F 224} Continued From page 15

transferred to the intensive care unit...Plan for this patient: 1. Pneumonia is improving...3. Atrial fibrillation with rapid ventricular response, heart rate is rate controlled, Cardizem drip has been off for over 24 hours. The patient will be discharged back to nursing home today..."

Review of Timeline of Events dated April 1, 2014, and signed by the DON, revealed, "...Timeline of Events...During MAR change-over for month ending March 2014 and beginning month April 2014, a medication error was observed. Upon investigation, it appears that resident (#3)...did not receive (resident's) scheduled Coumadin, Coreg, Digoxin, Cardizem; Lisinopril or Lipitor since (resident) was re-admitted to (facility) on 3/14/14..." Continued review of Timeline of Events revealed when the resident was readmitted to the facility on March 14, 2014, the resident's hospital discharge orders were faxed to the pharmacy. Further review of Timeline of Events revealed the facility's investigation determined the pharmacy received only pages 3, 4, 5, and 6 of a total of six pages. Continued review revealed the pharmacy did not receive pages 1 and 2 which consisted of the orders for the resident's Coumadin, Coreg, Digoxin, Cardizem, Lisinopril, and Lipitor.

Interview with the DON and Nurse Consultant #1 on April 15, 2014, at 2:45 p.m., in the Conference Room, revealed the DON's investigation of the medication errors revealed the nurse who faxed the resident's discharge orders from the hospital to the pharmacy did not verify with the pharmacy how many pages the pharmacy had received. Continued interview revealed when the resident's medications arrived from the pharmacy, the nurse matched the medications with the Physician

{F 224} appropriate. Results of audits of new Medication Reconciliation Procedure will be presented to the monthly Performance Improvement Committee by the DON for review and recommendations until desired threshold of 100% is met for three consecutive months/ then quarterly. A Performance Improvement Committee consisting of the Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Pharmacy Consultant, Quality Assurance Nurse, and MDS Nurses was conducted on 5/22/14, and results of the above audits were found to be in continued compliance. The audits will continue to be completed monthly for three months as a recommendation from this Performance Improvement Committee and will continue to be reviewed monthly by the Performance Improvement Committee for recommendations regarding monitoring frequency, adjustments to monitoring, and/or system changes. The Administrator and DON will follow up on recommendations from the Performance Improvement Committee to assure continued compliance.
The monthly Performance Improvement Committee consists of the Administrator, Medical Director, Business Office Manager, Director of Nursing, Assistant Director of Nursing, Human Resources Clerk, Clinical Records Clerk, Marketing/Admissions Director, MDS Coordinator, Assessment Nurse, Director of Activities, Director of Dietary, Director of Housekeeping/Laundry, Maintenance Director, Director of Social Services, Therapy Manager, Consultant Pharmacist, and Line Staff Nurse. 5/22/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(F 224)	Continued From page 16	(F 224)		

Order sheets and MARS which were generated from the pharmacy, and did not reconcile the medications, or the physician orders with the hospital discharge orders. Further interview with the DON and Nurse Consultant #1 confirmed resident #3 did not receive six ordered medications (Coumadin, Coreg, Digoxin, Cardizem, Lisinopril, Lipitor) from the time of the resident's admission to the facility on March 14, 2014, until the resident's discharge to the hospital on March 29, 2014 (a total of 15 days). Further interview with the DON and Nurse Consultant #1 confirmed the facility's failure to reconcile the resident's hospital discharge orders with the facility's admission orders placed the resident at risk for serious harm, and confirmed the facility neglected the resident's physical status by not administering prescribed medications.

Interview with the DON on April 16, 2014, at 12:40 p.m., in the Conference Room, confirmed the DON had questioned the admitting nurse of resident #3 about the resident not being admitted from the hospital with Coumadin orders. Continued interview with the DON confirmed the DON also did not reconcile the hospital discharge orders with the facility's admission orders at the time the DON became aware on March 16, 2014, the resident was not receiving Coumadin.

Interview with Hospitalist Physician #1 on April 21, 2014, at 10:26 a.m., by phone, confirmed the physician was one of resident #3's treating physicians. Further interview revealed, "...I would say the fact that (resident) did not receive medications led to the (resident's) hospitalization..." Continued interview confirmed the resident's Digoxin level "...was very low...", subtherapeutic, and confirmed the resident was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445802	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(F 224)	Continued From page 17	(F 224)		

"...critically ill..." necessitating the resident's transfer to the Intensive Care Unit (ICU). Further interview with Hospitalist Physician #1 confirmed when resident #3 was administered the resident's ordered medications (specifically Cardizem and Digoxin) the resident improved, and was able to be discharged back to the facility.

Interviews conducted with the DON and Nurse Consultant #1 during the course of the survey confirmed there was not a consistent medication reconciliation process in place for nursing staff to utilize when a resident was admitted/readmitted to the facility which resulted in the failure to provide six medications, therefore neglect, to resident #3.
C/O #33583

Validation of the Credible Allegation of Compliance was accomplished on-site on May 13, 2014, and May 14, 2014, through medical record reviews, review of facility documents, and interviews with Nursing and Administrative Staff.

The facility provided evidence of audits of reconciliation of admission/re-admission orders, in-service training for all nursing staff related to physician notification of medication errors, admission/readmission physician order and medication reconciliation, medication omissions, blood glucose monitoring and shift to shift audits of accu-checks and sliding scale insulin, sliding scale insulin orders, and physician standing orders, and the pharmacy procedure for medication orders.

The facility provided documentation of an emergency Performance Improvement Meeting held on April 28, 2014, to discuss the new

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 224}	Continued From page 18	{F 224}		

admission/readmission medication reconciliation process, pharmacy process, and physician notification process and provided evidence of establishing a Performance Improvement Committee to address the system failure for accurate medication verification, delivery and administration.

Medical record review of the closed chart of resident #3 revealed the resident's Physician Orders and Medication Administration Records were reconciled accurately on March 31, 2014. Resident #3 was discharged from the facility on April 1, 2014.

Medical record review of resident #33 revealed the resident was readmitted to the facility on May 8, 2014. Continued review of the physician orders dated May 8, 2014, revealed the orders has been verified with the physician and signed by two licensed nurses. Medical record review of the Medication Administration Record from May 8-13, 2014, revealed the resident received medications as ordered.

Interviews with Nursing Staff on all shifts May 13-14, 2014, throughout the facility, revealed the nursing staff had been in-serviced on the protocol for new admission/readmission medication order reconciliation, pharmacy protocol, medication errors, and physician standing orders.

The facility will remain out of compliance at a Scope and Severity level "E" a pattern of deficient practice that constitutes no actual harm with potential for more than minimal harm, that is not Immediate Jeopardy until it provides an acceptable plan of correction, and the corrective actions are verified onsite.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 281} SS=F	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	{F 281}	F 281	

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation, review of Medication Reviews/3 Month Review, review of facility policy, and interview, the facility failed to follow physicians orders for eleven residents (#3, #19, #14, #1, #10, #13, #24, #26, #28, #29, #30) of thirty-one residents reviewed. The facility's failure to follow physician's orders placed residents #3, #19, and #14 in Immediate Jeopardy(a situation in which a provider's noncompliance with one or more requirements of participation has caused or was likely to cause, serious injury, harm, impairment or death). The facility's systemic failure to ensure staff followed professional standards of practice in order to reconcile physician orders for accuracy and ensure medications were administered as ordered has the potential of Immediate Jeopardy for any resident who receives medication.

The Administrator, Regional Administrator Consultant, Assistant Director of Nursing, Nurse Consultant #1/Acting Director of Nursing, Nurse Consultant #2, Nurse Consultant #3, Vice-President of Client Operations, and Medical Director #1 were informed of the Immediate Jeopardy on April 24, 2014, at 10:55 a.m., in the Conference Room.

The Immediate Jeopardy was effective March 14, 2014, and was ongoing.

Christian Care Center of Rutherford County believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:

Corrective Actions for Targeted Residents

Resident #3 was transferred to acute care on 3/29/14. Resident #3 returned to the facility on 3/31/14. Resident #3's medications were reconciled from the previous provider accurately on 3/31/14 by the Director of Nursing (DON). Resident #3 was discharged from the facility on 4/1/14.
Resident #19's medication orders were reconciled on 4/17/14 by the DON. MD and Resident #19's family was notified of medication errors on 4/17/14.
Resident #14's accu-check time was changed from 6am to 7am on 4/21/14 by the MD to be closer to mealtime. Facility protocol for sliding scale insulin administration was discontinued on the Standing Orders by the Medical Director on 4/28/14. Resident #14's family was notified of medication errors on 4/21/14 by the DON.
Resident #1 was a closed chart.
Resident #24 was discharged from the facility on 4/23/14.
Resident #28 was out to hospital during the survey. Agency nurse had omitted topical treatments for Resident #28 and failed to communicate this to the Administrative Staff. Agency Nurses are supervised by the DON.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445882	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

{F 281} Continued From page 20

An extended survey was conducted on April 24, 2014.

The facility provided an acceptable Allegation of Compliance on May 8, 2014, and a revisit on May 13, 2014, and May 14, 2014, revealed the corrective actions implemented on May 2, 2014, removed the Immediacy of the Jeopardy.

Noncompliance for F-281 continues at a "F" level citation for the facility's monitoring the effectiveness of corrective actions in order to ensure sustained compliance and evaluation of the processes by the Quality Assurance Committee.

The findings included:

Resident #3 was admitted to the facility on December 26, 2012, and readmitted to the facility on March 14, 2014, with diagnoses including Respiratory Failure, Chronic Atrial Fibrillation, Sinonal Node Dysfunction, Pneumonia, Chronic Obstructive Pulmonary Disease, Hypertension, and Cerebral Vascular Accident.

Medical record review of the hospital Discharge Med (Medication) Rec (Reconciliation) form dated March 14, 2014, revealed the hospital Discharge Med Rec form contained a total of 6 pages of medications ordered for the resident upon discharge from the hospital and readmission to the facility. Continued review revealed the Discharge Med Rec form for pages 1 and 2 included physician's orders for the resident to continue the following medications on readmission to the facility: Coumadin (blood thinner) 2.5 mg (milligrams) and 1 mg daily for a total of 3.5 mgs at 4:00 p.m., Lipitor (statin drug

{F 281} Beginning 4/24/14, Agency Nurses will be in-serviced by the DON prior to reporting to the floor for the first time regarding administering medications and performing all treatments as ordered by the physician – without omissions. Resident #28's medications were reconciled accurately by the DON on 4/24/14 upon resident's return to the facility. Medications for Residents #26, #10, #13, #30 and #29 were reconciled by the DON on 4/25/14.

Identification of Other Residents with Potential to be Affected

A 100% audit of active residents' admission/ re-admission orders from the facility pharmacy matching the discharge orders from the previous provider, ensuring all pages were faxed to the pharmacy and reconciled correctly onto the MARs, was conducted by the DON and Nurse Consultant beginning on 4/18/14 and completed on 4/22/14. The results of these admission/re-admission order audits and the action taken by the DON and Nurse Consultant are as follows: orders not transcribed correctly onto the MAR affected nine residents. These residents' medications were reconciled correctly onto the MAR by the Nurse Consultant on 4/22/14. Omission of medication administration doses affected two residents. MD and family notified of errors on 4/22/14 by the Nurse Consultant. Nursing education of licensed staff by the DON occurred regarding these errors on 4/22/14. On 4/25/14, the DON re-wrote clarification orders for all resident-charts cited for this issue by matching current orders to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445802	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

(F 281) Continued From page 21

for cholesterol management) 10 mg at bedtime, Coreg (heart medication to regulate heart rate) 25 mg twice per day, Digoxin (heart medication to slow heart rate and control rhythm) 0.125 mg once per day, Cardizem (heart medication to control heart rate and blood pressure) 120 mg once per day, and Lisinopril (medication to control high blood pressure) 10 mg once per day.

Medical record review of Physician's Orders (recapitulation orders) for March 14, 2014, through March 31, 2014, revealed no orders for the following medications: Coumadin, Lipitor, Coreg, Digoxin, Cardizem, or Lisinopril.

Medical record review of the Medication Record (form used to document medication administration: MAR) dated March 14, 2014, through March 31, 2014, revealed two pages of medications, neither of which included the Coumadin, Lipitor, Coreg, Digoxin, Cardizem, and Lisinopril.

Medical record review of a nurse's note dated (incorrectly) March 30, 2014, (correct date is March 29, 2014), revealed resident #3 was transferred to the hospital for evaluation and treatment.

Medical record review of an Emergency Room Provider Report dated March 29, 2014, revealed the resident was evaluated in the Emergency Room.

Medical record review of emergency room lab report dated March 29, 2014, revealed the level of digoxin medication for resident #3 was documented as "< 0.2 L (low)"

(F 281) current MARs to ensure physician's orders are followed for accu-checks and sliding scale insulin and that medication reconciliation is correct. The remaining residents' medications were reconciled by the Nursing Staff on 4/30/14 during MAR change-over procedure. This MAR change-over was double-checked by the Nurse Consultant on 4/29/14 and 4/30/14 to ensure accurate medication reconciliation onto new MAR occurred.

Systematic Changes

Beginning 4/22/14, the new procedure was initiated of the Consultant Pharmacist conducting a daily audit, on-site at the facility, of hospital/ previous provider discharge orders to ensure accurate medication reconciliation from the previous provider was received by the pharmacy—and that all pages of admission/re-admission orders were received by the pharmacy. On-call pharmacist will conduct this audit, on-site at the facility, of medication reconciliation of new admissions/re-admissions on the weekends. This daily audit of admission/re-admission orders by the pharmacist will be on-going until desired threshold of 100% is met for three consecutive months; then quarterly.
On 4/24/14, the ADON immediately educated all nurses working both shifts that day regarding the necessity of performing accu-checks and administering sliding scale insulin as ordered by the physician; with no omissions. These accu-check performance/ sliding scale insulin administration in-services are ongoing by the ADON until all licensed staff is educated regarding following

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

{F 281} Continued From page 22

Medical record review of treating hospital physician, and consulting physicians' reports from March 29, 2014, through March 31, 2014, revealed the resident required medical treatment in the Intensive Care Unit. Review of the hospital records revealed the resident was "...critically ill."

Interview with Hospitalist Physician #1 on April 21, 2014, at 10:26 a.m., by phone, confirmed the resident was hospitalized in the ICU with Atrial Fibrillation, and confirmed the resident's digoxin level "...was very low..." Continued interview confirmed the resident was "...critically ill..." upon admission to the hospital. Further interview confirmed when the resident was administered Cardizem and Digoxin (two of the medications the resident had not been administered for 15 days) the resident's condition improved and was able to be discharged back to the facility.

Interview with the DON and Nurse Consultant #1 on April 15, 2014, at 2:45 p.m., in the Conference Room, revealed the DON's investigation of the medication errors revealed the nurse who faxed the resident's discharge orders from the hospital to the pharmacy did not verify with the pharmacy how many pages the pharmacy had received. Continued interview revealed when the resident's medications arrived from the pharmacy, the nurse matched the medications with the Physician Order sheets and MARS which were generated from the pharmacy, and did not reconcile the medications, or the physician orders with the hospital discharge orders. Further interview with the DON and Nurse Consultant #1 confirmed resident #3 did not receive six ordered medications (Coumadin, Coreg, Digoxin, Cardizem, Lisinopril, Lipitor) from the time of the resident's admission to the facility on March 14,

{F 281} physician's orders for accu-checks performance/sliding scale insulin administration; completion date of 4/29/14. Beginning 4/24/14, the new procedure of each licensed nurse performing an accu-check performance/sliding scale insulin administration audit every shift with oncoming nurse for accuracy and completion of documentation onto the Diabetic Flow Record. DON/ADON will follow up on the results of these accu-check performance/ sliding scale insulin administration audits on a daily basis. Nursing Supervisor will follow up on these accu-check/sliding scale insulin audit results on the weekends. On 4/18/14, the DON initiated in-services for licensed staff regarding the new Medication Reconciliation Procedure of two nurses reconciling discharge orders from the hospital/previous provider with the physician's orders/MARs sent by the facility pharmacy with both nurses' signatures on the hospital discharge orders and the facility pharmacy MARs. In-service also included the Admitting Nurse will place a telephone call to the newly-admitted resident's attending physician to review, adjust, and accept admission orders. Any clarification orders given by the admitting physician will be taken by the Admitting Nurse as a telephone order and faxed to the pharmacy with the admission/re-admission orders brought by EMS/accompanied with resident. This education was ongoing by the DON until all nurses were educated, with completion by 4/29/14. All facility licensed staff attended one of these in-services. Beginning 4/18/14, the new procedure of the DON reconciling the admission/re-admission

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

{F 281} Continued From page 23

2014, until the resident's discharge to the hospital on March 28, 2014 (a total of 15 days). Further interview with the DON and Nurse Consultant #1 confirmed the facility's failure to reconcile the resident's hospital discharge orders with the facility's admission orders placed the resident at risk for serious harm.

The facility's failure to reconcile hospital discharge orders with facility admission orders, resulted in resident #3 not receiving six prescribed medications, which resulted in the resident's hospitalization. The facility's failure to follow accepted standards of practice for medication reconciliation placed resident #3 in Immediate Jeopardy.

Resident #19 was admitted to the facility on February 26, 2014, and readmitted to the facility on March 27, 2014, with diagnoses including Acute Edema, Hypertension, Chronic Kidney Disease, Heart Disease, End Stage Renal Disease, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Parkinson's Disease, and Dementia.

Medical record review of the hospital Discharge Med Rec form dated March 27, 2014, revealed no order for PhosLo (Calcium Acetate) 667 mg, (a medication used to bind with phosphorus in the body to decrease the level of phosphorus in the blood). Continued review also revealed no order for Crestor 20 mg (an antistatin medication used to lower cholesterol). Further review of the Discharge Med Rec form revealed orders for Mirtazapine 7.5 mg (an antidepressant medication) and Protonix 40 mg (a stomach medication used to control acid in the stomach).

{F 281}

orders daily was initiated. This audit of reconciling admission/re-admission orders will be completed by the Nursing Supervisor on weekends or in the absence of the DON. Newly-hired nurses and agency nurses will be educated by the DON, prior to reporting to the floor, of the new Medication Reconciliation Procedure of two nurses verifying hospital/previous provider discharge orders with orders sent by facility-pharmacy orders, verifying admission orders with the attending physician, and faxing only the hospital/previous provider's set of orders to the pharmacy. On 4/1/14, Pharmacy personnel was in-serviced by the Regional Director regarding verifying all numbered pages of admission/re-admission orders and calling the facility to verify number of pages faxed. On 4/15/14, Pharmacy personnel was in-serviced by the Regional Director to reconcile all orders received from the facility against the hard-copy chart orders as a final review. Beginning 4/25/14, the new procedure of the pharmacy staff at Pharmacy Office #1, home office, is assuming the function of order entry to ensure initial medication reconciliation accuracy was initiated. The pharmacist at Pharmacy Office #2 will be the second check once the order is filled. Beginning 4/25/14, all new orders, including admission/re-admission orders, will be reviewed by four pharmacy staff by the following procedure:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445592	A. BUILDING: _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(F 281)	Continued From page 24 Medical record review of Physician's Orders (Recapitulation orders) dated March 27, 2014, through March 31, 2014, revealed a medication order for "...Calc (calcium) Acetate Cap 667 mg 1 capsule PO (by mouth) with meals...For PhosLo..." Continued review of Physician's Orders revealed a medication order for "...Crestor tab 20 mg 1 tablet PO at bedtime..." Further review of the Physician's Orders for March 27, 2014, through March 31, 2014, revealed no medication orders for Mirtazapine (Remeron) or Protonix. Medical record review of the MAR dated March 27, 2014, through March 31, 2014, revealed the resident received both Calcium Acetate and Crestor from March 28, 2014, through March 31, 2014. Continued review of the MAR revealed the resident was not administered Mirtazapine or Protonix. Medical record review of the Physician's Orders and MARs dated April 1, 2014, through April 31, 2014, revealed the pharmacy had included the orders for Mirtazapine and Protonix which had originally been omitted from the resident's readmission to the facility on March 27, 2014. Continued review of the Physician's Orders and MARS for April 2014, revealed nursing discontinued these medications during reconciliation of the March 27, 2014, Physician's Orders with the April, 2014 Physician's Orders provided by the pharmacy. Further review of the April Physician's Orders and MARS revealed no orders for the Calcium Acetate or Crestor (which had been omitted by pharmacy from the original hospital discharge orders and Physician's Orders March 27, 2014). Further review of the April Physician's Orders and MARS revealed nursing	(F 281)	• Order entry will be performed by pharmacy technician at Pharmacy Office #1. • Order entry/clinical review for accuracy will be conducted by the pharmacist at Office #1. • Packaging of product will be performed by the pharmacy technician at Pharmacy Office #2. • Final review of product and medication orders will be performed by the pharmacist at Pharmacy Office #2. Due to Pharmacy Offices #1 and #2 being on the same computer system, this new pharmacy procedure will not impede nor slow down medication and MAR delivery to the facility. Pharmacy Office #2's pharmacy technicians and pharmacists were educated on 4/29/14 by the Vice President/Clinical Director of Pharmacy Services in person regarding the new procedure of Pharmacy Office #1 assuming the function of order entry and the procedure of orders being reviewed by four pharmacy staff, from both offices, to ensure accurate medication reconciliation from previous provider. 100% of pharmacy technicians and pharmacists were present for this in-service. No agency staff is used by Pharmacy #2. Pharmacy #1's pharmacy technicians and pharmacists were educated on 4/25/14 by the Vice President/Clinical Operations regarding the new procedure of Office #1 assuming all order entries and the procedure of orders being reviewed by four pharmacy staff from both offices. This in-service was repeated by the Pharmacy Operations Manager on 4/29/14; this ensured 100% pharmacy technicians and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445692	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

{F 281} Continued From page 25

changed the orders to match the March 27, 2014 Physician's orders and MARS which had been added by the pharmacy in error. Therefore resident #19 continued to be administered 2 medications without an order (Calcium Acetate and Crestor), and failed to be administered 2 medications (Mirtazapine and Protonix) which had been ordered by the discharging hospital from March 27, 2014, through April 17, 2014.

Medical record review of Medication Reviews 3 Month Review dated April 4, 2014, revealed "... (Facility) Medication Reviews 3 Month Review...3-27-14 re-admit...pharmacy omitted...Protonix...Remeron (Mirtazapine), the pharmacy also added Crestor and PhosLo (Calcium Acetate) without an order. This was not caught by nursing. The April POS (Physician's orders) from the pharmacy were correct, however when the nurse checked the POS (Physician's orders) (the nurse) changed all the orders to match March's MAR..." Further review of facility documentation revealed the Medication Reviews 3 Month Review was sent by email from Nurse Consultant #1 to the Director of Nursing (DON) and Administrator on April 4, 2014.

Interview with the DON and Nurse Consultant #1 on April 17, 2014, at 2:55 p.m., in the Conference Room, confirmed the resident's March 2014, and April 2014, Physician's orders and MARs were incorrect. Continued interview confirmed the resident continued to receive discontinued medications, PhosLo (Calcium Acetate) and Crestor without a physician's order, and confirmed the resident did not receive ordered medications Mirtazapine and Protonix from March 27, 2014, until April 17, 2014. Further interview confirmed both the DON and Nurse Consultant

{F 281} pharmacists were educated. Newly-hired pharmacy technicians and pharmacists will be educated during their orientation period by the Pharmacy Operations Manager regarding new order entry system, new facility-cover sheets for faxing admission/re-admission orders to the pharmacy, and on-site daily audits of admission/re-admission orders for medication reconciliation accuracy.
Beginning 4/28/14, the pharmacy will provide the facility with a cover sheet for admission/ re-admission orders that will consist of a bar code that will move these orders to an "as soon as possible" status for the pharmacy. This cover sheet will also consist of nurse contact number for any clarification issues, and number of pages faxed to the pharmacy.
Vice President/Clinical Director of Pharmacy Services conducted mandatory in-services for facility licensed staff on 4/28/14 and 4/29/14 regarding utilization of the new Fax Cover Sheets for Admissions Office, new Fax Cover sheets for nurses to utilize for admissions/ re-admissions, and tips for writing and sending medication orders. 100% of facility-licensed staff attended one of these in-services. Newly-hired and agency licensed staff will be in-serviced by the DON, prior to reporting to the floor for the first time, regarding the new pharmacy cover sheet to be utilized with admission/re-admission orders to place these orders in a "priority" status for the pharmacy. Newly-hired nurses and agency nurses will be educated by the DON, prior to reporting to the floor for the first time, of the new Medication Reconciliation Procedure of two nurses verifying hospital/previous provider discharge

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

{F 281} Continued From page 26

#1 became aware the resident was receiving medications that were not ordered, and became aware the resident was not receiving ordered medications on April 4, 2014, and confirmed both neglected to correct the medication errors, until brought to their attention by the surveyor on April 17, 2014.

Interview with Pharmacist #1 on April 22, 2014, at 1:25 a.m., in the conference room, , revealed the facility identified a breakdown in communication between the pharmacy and the facility in early April. Further interview revealed prior to the last Performance Improvement meeting held April 10, 2014, the pharmacy did not compare/reconcile hospital discharge medication to the facility admission physician orders. Further interview revealed "...assumed orders verified prior to contact with (pharmacy) or that the nursing facility made a clarification order prior to contacting the (Pharmacy)..."

The failure of the facility nursing staff to follow the standard of practice to accurately reconcile hospital discharge orders with facility admission orders, and the failure to act on knowledge of the medication errors upon discovery of the errors placed resident #19 in immediate Jeopardy.

Resident #14 was admitted to the facility on March 31, 2014, discharged to the hospital on April 1, 2014, related to care for a cyst, and readmitted to the facility on April 11, 2014, with diagnoses including Diabetes Mellitus, Hypertension, Peripheral Neuropathy, Congestive Heart Failure, and Acute Renal Failure.

Medical record review of the physician order dated March 31, 2014, revealed "...Accucheck

{F 281} orders with orders sent by facility-pharmacy orders, verifying admission orders with the resident's attending physician, and faxing only the set of orders brought by EMS or accompanied by the resident, to the pharmacy. Standing Orders were revised and signed by the Medical Director on 4/28/14. Facility protocol for sliding scale insulin administration was discontinued by the Medical Director on 4/28/14. Per the Medical Director's approval, sliding scale insulin administration will follow the physician's discharge orders from the hospital/previous provider. Pharmacy was notified of this revision for Standing Orders on 4/29/14 by the DON. Pharmacy staff was in-serviced regarding standing orders by the Regional Director of Pharmacy on 4/28/14 and 4/29/14. These Standing Orders were placed in the residents' charts and in the front of the MARs by the DON on 4/29/14, who instructed each nurse when and how to use these orders and where they could be located; completed 5/1/14.

Monitoring

The results of the daily accu-check/sliding scale insulin audits will be presented by the ADON to the monthly Performance Improvement Committee for review and recommendations until desired threshold is met for three consecutive months; then quarterly. The results of the daily audits of the new Medication Reconciliation Procedure of verifying all admission/re-admission orders by two nurses, verifying admission orders with the resident's attending physician, and faxing the orders provided by the EMS/accompanied

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	207 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

{F 281} Continued From page 27

(monitoring of blood sugar) AC + HS (before meals and bedtime)..."

Medical record review revealed no documentation of the monitoring of the blood sugar level before supper for March 31, 2014 as ordered by the physician.

Medical record review of the hospital Discharge Med Rec dated April 10, 2014, for the facility readmission on April 11, 2014, revealed an order for sliding scale insulin (SSI). The facility readmission orders dated April 11, 2014, revealed the hospital SSI order reverted to the facility SSI protocol (effective on September 2012) as follows "Novolin R (fast acting insulin, medication to control blood sugar) inject subcutaneously (under the skin) as directed per SSI (Sliding Scale Insulin): If glucose (blood sugar) < (less than) 60 give snack & (and) recheck in 30 minutes, if recheck still <60 give Glucagon UD (Unit Dose); 251-300= 4 units (give 4 units); 301-350=6 units; 351-400=8 units; 401-450= 10 units; Recheck in 1HR (hour) using above sliding scale if BG (Blood Glucose) > (greator than) 300; >450= (means) call MD (physician) for orders recheck in 1 HR or per MD..." Further review of the readmission orders revealed "...Accucheck AC + HS..."

Medical record review of the Diabetic Medication Administration Record dated April 2014, revealed the accuchecks were to be completed at 6:00 a.m. (morning); 11:00 a.m.; 5 p.m. (evening); and 9 p.m. Further review of the form revealed the following:
1. April 18, 2014, at 5:00 p.m. the accucheck was 253 and no insulin administration (should have administered 4 units);
2. April 19, 2014, at 5:00 p.m. the accucheck

{F 281} by the resident to the pharmacy will be presented by the DON to the monthly Performance Improvement Committee for review and recommendations until desired threshold of 100% has been met for three consecutive months; then quarterly. A Performance Improvement Committee consisting of the Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Pharmacy Consultant, Quality Assurance Nurse, and MDS Nurses was conducted on 5/22/14, and results of the above audits were found to be in continued compliance. The daily accu-checks/sliding scale insulin administration audits and the daily medication reconciliation audits will continue to be completed daily for three months as a recommendation from this Performance Improvement Committee, and will continue to be reviewed monthly by the Performance Improvement Committee for recommendations regarding monitoring frequency, adjustments to monitoring, and/or system changes. The Administrator and DON will follow up on recommendations from the Performance Improvement Committee to assure continued compliance. The Performance Improvement Committee consists of the Administrator, Medical Director, Business Office Manager, Director of Nursing, Assistant Director of Nursing, Human Resources Clerk, Clinical Records Clerk, Marketing/Admissions Director, MDS Coordinator, Assessment Nurse, Director of Activities, Director of Dietary, Director of Housekeeping/Laundry, Maintenance Director, Director of Social Services, Therapy Manager, Consultant Pharmacist, and Line-Staff Nurse. 5/22/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 281}	Continued From page 28	{F 281}		

was 301 and no insulin administration (should have administered 6 units).
3. April 19, 2014, at 9:00 p.m. no accucheck was obtained;
4. April 20, 2014, at 11:00 a.m. the accucheck was 305 and no insulin administration (should have administered 6 units);
5. April 21, 2014, before the breakfast meal, no accucheck was obtained; and on
6. April 23, 2014, at "6A (6:00 a.m.)" no accucheck was obtained.

Interview with Licensed Practical Nurse (LPN) #1 assigned to resident #14, on April 21, 2014, at 11:15 a.m., on the 100 hall revealed "...the night nurse (7:00 p.m. to 7:00 a.m. shift) obtains the blood sugar..." Further interview confirmed the blood sugar level for April 21, 2014, at 6:00 a.m. was not documented on the Diabetic Medication Administration Record.

Interview with Nurse Consultant #1/Acting Director of Nursing, on April 21, 2014, at 11:38 a.m., in the Conference Room confirmed the blood sugar level and the insulin administration when the blood sugar was elevated was to be documented on the Diabetic Medication Administration Record as ordered by the physician. Further interview confirmed the April 2014, Diabetic Medication Administration Record lacked documentation of blood sugar levels, as ordered by the physician, on April 19, 2014, at 9:00 p.m. and on April 21, 2014, before the breakfast meal . Further interview confirmed the insulin should have been administered per the physician's order and the number of units administered was to be documented on April 18 and 19, 2014, at 5:00 p.m. and on April 20, 2014, at 11:00 a.m. due to the elevated accucheck

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 281}	Continued From page 29 results. Interview with Medical Director #2, on April 21, 2014, at 11:52 a.m., in the Conference Room confirmed "...expect (resident #14) should have gotten sliding scale (insulin) per (physician's) order (when blood sugar elevated)..." Interview with LPN #5, on April 23, 2014, at 7:45 a.m., at the 200/300 nursing station, and Nurse Consultant #1/Acting Director of Nursing present, confirmed LPN #5 had been responsible for resident #14 during the 7:00 p.m.-7:00 a.m. shift and had not obtained the blood sugar level the morning of April 23, 2014. Interview with LPN #4, and observation on April 23, 2014, at 7:50 a.m., and Nurse Consultant #1/Acting Director of Nursing present, outside the room of resident #14, confirmed LPN #4 was responsible for resident #14 for the 7:00 a.m.-7:00 p.m. shift had not obtained the blood sugar level the morning of April 23, 2014. When LPN #4 was asked if the blood sugar had been obtained this nurse stated "No, the night shift (7:00 p.m.-7:00 a.m.) does it." Interview with Nurse Consultant #1, on April 23, 2014, at 1:20 p.m., in the Conference Room, confirmed LPN's #4 and #5 had not obtained the blood sugar level per the physician's order the morning of April 23, 2014. Interview with LPN #9 and Nurse Consultant #2, on April 24, 2014, at 10:15 a.m., at the 100/200 nursing station, confirmed the resident had been admitted on March 31, 2014, at 2:50 p.m. and had been discharged before breakfast on April 1, 2014. Further interview confirmed the accucheck	{F 281}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 281}	Continued From page 30	{F 281}		

for March 31, 2014, at 5:00 p.m. was not obtained.

The facility's failure to follow the physician's orders to monitor the blood sugar level and the failure to follow the physician's order to administer the prescribed insulin when the blood sugar was elevated placed resident #14 in Immediate Jeopardy.

Review of the hospital Discharge Medication Reconciliation dated April 10, 2014, for the facility readmission on April 11, 2014, for resident #14 included an order for "...Gabapentin (medication to treat nerve pain) 800 mg (milligrams) po (by mouth) every 6 hours..."

Medical record review of the facility readmission orders dated April 11, 2014, and the April 11-30, 2014, MAR documentation revealed the pharmacy failed to transcribe the Gabapentin 800 mg po every 6 hours onto the MAR.

Interview with Nurse Consultant #1, on April 17, 2014, at 2:20 p.m., in the Conference Room, confirmed the facility had failed to reconcile the hospital discharge medications with the facility readmission orders therefore failed to follow the physician order. Further interview confirmed the Director of Nursing had conducted an audit upon readmission on April 11, 2014, to review the medication reconciliation and failed to identify the omission of the Gabapentin order for resident #14.

Interview with Pharmacist #1 on April 22, 2014, at 1:25 a.m., in the conference room, revealed the facility identified a breakdown in communication between the pharmacy and the facility in early

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 281}	Continued From page 31	{F 281}		

April. Further interview revealed prior to the last Performance Improvement meeting held April 10, 2014, the pharmacy did not compare/reconcile hospital discharge medication to the facility admission physician orders. Further interview revealed "...assumed orders verified prior to contact with (pharmacy) or that the nursing facility made a clarification order prior to contacting the (Pharmacy)..."

Resident #1 was admitted to the facility on March 11, 2014, with diagnoses including Diabetes Mellitus Type II, Morbid Obesity, Hypertension, and Peripheral Vascular Disease.

Medical record review of a nursing note dated March 25, 2014, revealed the resident was discharged from the facility on March 25, 2014.

Medical record review of the hospital Discharge Report dated March 11, 2014, revealed an order for "...Metoprolol (blood pressure medication) 12.5 mg (milligrams) by mouth, twice daily..."

Medical record review of the facility March 11, 2014, admission orders and the March 11-25, 2014, Medication Record (MAR documentation of medication administration) revealed Metoprolol was not included.

Medical record review of the Nurse's Notes revealed the following blood pressure readings: March 11, 2014: 157/93, March 12, 2014: 146/89, March 13, 2014: 139/74, March 14, 2014: 125/75, March 23, 2014: 153/96, March 24, 2014: 147/97. The normal range is 120/80.

Interview with the Director of Nursing and Nurse Consultant #1, on April 15, 2014, at 2:35 p.m., in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	207 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(F 281)	Continued From page 32	(F 281)		

the Conference Room, confirmed the facility failed to follow the physician's order when the facility failed to accurately reconcile the hospital discharge orders with the facility admission orders for Metoprolol from the Admission on March 11, 2014 through the discharge on March 28, 2014.

Resident #10 was admitted to the facility on March 28, 2014, and readmitted to the facility on April 9, 2014, with diagnoses including Diabetes Mellitus Type II, Arteriosclerotic Dementia, Major Depressive Disorder, Anxiety, and Affective Psychoses.

Medical record review of the hospital discharge medications dated March 27, 2014, revealed an order for "...lubricating top (topical) jelly bacteriostatic apply small amount to affected area two times a day as needed..."

Medical record review of the March 28, 2014, facility admission orders and the Medication Record (MAR documentation of medication administration) revealed no documentation for the order of lubricating top jelly bacteriostatic.

Interview with Nurse Consultant #1, on April 17, 2014, at 8:45 a.m., in the Conference Room confirmed the facility failed to accurately reconcile the hospital discharge order with the facility admission order for the March 28, 2014, admission. Further interview confirmed the facility failed to follow the physician orders for the lubricating jelly ordered on March 28, 2014.

Interview with Pharmacist #1, on April 22, 2014, beginning at 1:25 p.m., in the Conference Room confirmed the lubricating jelly was "...a blatant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 281}	Continued From page 33	{F 281}		

omission by pharmacy..."

Resident #13 was admitted to the facility on February 24, 2014, and readmitted to the facility on March 25, 2014, with diagnoses including Aftercare for Joint Replacement, Hyperlipidemia, Hypertension, Muscle Weakness, and Lack of Coordination.

Medical record review of hospital Medication Discharge Report dated February 24, 2014, revealed an order for Cranberry Liquid Supplement, by mouth, once every day, 7 days.

Medical record review of Physician's Orders dated February 24, 2014, through February 28, 2014, revealed no order for Cranberry Liquid Supplement.

Medical record review of Medication Record (MAR) dated February 24, 2014, through February 28, 2014, revealed the resident did not receive Cranberry Liquid Supplement for that time period.

Medical record review of the hospital Medication Discharge Report dated March 25, 2014, revealed an order for "...aspirin 325 mg (milligrams), by mouth, twice daily..." Continued review revealed an order Cranberry Liquid Supplement, by mouth, once every day, 7 days.

Medical record review of the Physician's Orders dated March 25, 2014, through March 31, 2014, revealed no order for aspirin. Continued review of the Physician Orders revealed an order "...Cranberry Liquid Supplement take PO (by mouth) QD (every day)..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(F 281)	Continued From page 34	(F 281)		

Medical record review of the Medication Record (MAR) dated March 25, 2014, through March 31, 2014, revealed a handwritten notation for "...ASA (aspirin) 325 mg 1 PO BID (twice daily)..." Continued review of the MAR revealed the resident was administered the aspirin March 26, 2014, through March 31, 2014. Further review of the MAR revealed the Cranberry Liquid Supplement was on the MAR, however was not given March 26, 2014, through March 31, 2014

Interview with Nurse Consultant #1 on April 17, 2014, at 9:50 a.m., in the Conference Room, confirmed the resident's Physician Orders and MARs were not complete, and the resident did not receive the Cranberry Supplement as ordered for February 24, 2014, through February 28, 2014. Continued interview confirmed the hospital discharge records for March 25, 2014, included an order for Aspirin 325 mg, and confirmed the Physician Order sheets for March 25, 2014, through March 31, 2014, did not contain an order for Aspirin. Further interview confirmed the MAR for the same time period had Aspirin handwritten on the MAR, and confirmed the resident had received Aspirin March 26, 2014, through March 31, 2014, without a facility physician order. Continued interview with Nurse Consultant #1 confirmed the resident had an order for Cranberry Supplement, and confirmed the cranberry supplement had not been administered as ordered March 26, 2014, through March 31, 2014.

Resident #24 was admitted to the facility on April 2, 2014, with diagnoses including Anemia, Dementia, Parkinson's Disease, and Chronic Kidney Disease Stage 3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 281}	Continued From page 35	{F 281}		

Medical record review of the hospital discharge orders dated April 2, 2014, revealed a medication order for "...Melatonin (herbal medication prescribed for sleep) 4 mg daily at 1800 (6:00 p.m.)...Latuda (an atypical antipsychotic medication prescribed for anxiety) 20 mg Twice daily with meals...Latuda 10 mg every 6 hours as needed...for anxiety..."

Medical record review of the Physician's Orders dated April 2, 2014, through April 30, 2014, revealed an order for "...Melatonin 5 mg 1 tab (tablet) PO at 6 p.m..." Continued review of the Physician Orders revealed no order for Latuda.

Medical record review of the MAR dated April 2, 2014, through April 30, 2014, revealed the resident was administered Melatonin 5 mg from April 4, 2014, through, April 20, 2014. Continued review of the MAR revealed Latuda 20 mg twice a day and Latuda 10 mg every 6 hours as needed was handwritten on the form. Further review revealed the resident was administered Latuda 20 mg twice a day from April 3, 2014, through April 8, 2014, and was administered Latuda 10 mg April 4, 2014, through April 7, 2014,one time daily. Continued review of the medical record revealed nursing did not contact the physician to obtain clarification order for the discrepancy between the hospital discharge orders and the Physician's Orders.

Review of the facility documentation entitled New Admission/Readmission Audits dated April 3, 2014, revealed resident #24's admission orders had been listed as audited and initialed by the DON as being completed and correct.

Interview with Nurse Consultant #1/Acting DON

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(F 281)	Continued From page 36	(F 281)		

on April 21, 2014, at 4:05 p.m., in the Conference Room, confirmed the Physician Orders and the MAR had the wrong dose of Melatonin and did not match the discharge orders from the hospital. Further interview confirmed the resident was administered the wrong dose of Melatonin from April 2, 2014, through April 20, 2014. Continued interview confirmed the MAR included medication administration of Latuda 20 mg had been administered April 3, 2014, through April 8, 2014, and Latuda 10 mg was administered, April 4, 2014, through April 7, 2014. Further interview confirmed Latuda was not on the Physician's Order for April 2014, and the resident received the medication without a physician's order. Further interview with Nurse Consultant #1/Acting DON confirmed the resident's hospital discharge orders and admission orders were documented as being audited and correct by the DON. Continued interview confirmed the resident's medications had not been corrected after the audit by the DON.

Resident #26 was admitted to the facility on April 1, 2014, with diagnoses including Parkinson's Disease, Hypertension, Chronic Obstructive Pulmonary Disease, and Chronic Ischemic Heart Disease.

Medical record review of the hospital Medication Discharge Report dated April 1, 2014, revealed "...Tylenol 500 mg (milligrams) by mouth (no frequency of administration included in the order)..."

Medical record review of the facility April 1, 2014, admission orders and the April 2014, Medication Record (MAR documentation of medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 281}	Continued From page 37	{F 281}		

administration) of the Tylenol was not included.

Medical record review of the telephone orders revealed no order to clarify the Tylenol order.

Interview with Nurse Consultant #1/Acting Director of Nursing, on April 21, 2014, at 4:00 p.m., in the Conference Room, revealed the Tylenol order would "...revert to standing orders..."

Interview with Nurse Consultants #1/Acting Director of Nursing and Nurse Consultant #2, on April 22, 2014, at 8:45 a.m., in the Conference Room, confirmed the Tylenol order had not been clarified for resident #26.

Interview with Pharmacist #1, on April 22, 2014, at 2:45 p.m., by telephone, revealed the pharmacy had called the facility on April 1, 2014, at approximately 4:30 p.m., to clarify the Tylenol order due to lack of a frequency of administration. Further interview revealed the nurse, the admission nurse for resident #26, taking the call would get a clarification order. Further interview revealed the pharmacy called the facility at 7:00 p.m., and talked with resident #26 admission nurse, asking the status of the clarification order for the Tylenol. Further interview revealed resident #26 admission nurse was not able to obtain a clarification order and would use the standing orders until the order was clarified. Further interview with the Pharmacist #1 revealed the pharmacy printed the admission orders and MAR without the Tylenol and brought those to the facility.

Interview with Licensed Practical Nurse (LPN) #1, on April 22, 2014, at 8:20 a.m., on the 100 hall,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 281}	Continued From page 38	{F 281}		

revealed this nurse had been hired about three weeks ago and today was the third day on the 100/200 unit. Further interview revealed LPN #1 was not aware of the location of the standing orders on the 100/200 unit. Further interview revealed the 200/300 and 300/400 units had the standing orders on a clip board. Further interview revealed LPN #1 would have to go to the other units if there was a need to refer to the standing orders.

Interview with LPN #2, on April 22, 2014, at 9:08 a.m., on the 200/300 unit and with LPN #3, working on the 300/400 unit, on April 22, 2014, at 9:12 a.m., in the Conference Room, revealed Medical Director #1 and Medical Director #3 had separate undated Standing Orders available for use by the nursing staff. Further interview with LPN's #2 and #3 revealed there were no Standing Orders for Medical Director #2.

Interview with Nurse Consultant #1/Acting Director of Nursing, on April 22, 2014, at 9:30 a.m., in the Conference Room, confirmed the two separate undated Standing Orders available for use on the 200/300 and 300/400 units were not the current Standing Orders. Further interview confirmed Medical Directors #1 and #3 had signed new Standing Orders in September 2012. Further interview confirmed Medical Director #2 had not signed the 2012 Standing Orders. Further interview confirmed the facility nurses would not be able to follow the physician's Standing Orders due to the current, 2012 Standing Orders, were not available to the nursing staff.

Interview with Medical Director #3, on April 22, 2014, at 10:00 a.m., in the Conference Room, revealed "...the standing orders have been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 281}	Continued From page 39	{F 281}		

discussed long time ago...have modified the SSI in the past year...tried to do SSI uniformly between all doctors...the old set (of standing orders) was from 2011 and was not aware they were still in use..."
Resident #28 was admitted to the facility on April 9, 2014, with diagnoses including Hyponatremia, Congestive Heart Failure, and Chronic Obstructive Pulmonary Disease, and was discharged from the facility on April 17, 2014.

Medical record review of the Physician's Orders dated April 9, 2014, through April 30, 2014, revealed an order for "...Nystatin oin (ointment) 10000 Apply topically to affected area twice daily...Treatment drug to document on TAR (treatment administration record) only..."

Medical record review of the TAR dated April 9, 2014, through April 30, 2014, revealed "...Nystatin- apply to affected area twice daily...8a (8:00 a.m.) 4 p (4:00 p.m...) Continued review of the TAR revealed the resident was administered the Nystatin ointment April 10, 2014, through April 17, 2014, at 8 a.m., however no documentation the resident received the 4 p.m. dose.

Interview with Licensed Practical Nurse (LPN) #7/Treatment Nurse on April 22, 2014, at 9:30 a.m., in the Conference Room, confirmed the resident did not receive the 4:00 p.m. dose as ordered. Continued interview confirmed LPN #7 "...spoke with the agency nurse..." regarding the resident not receiving the scheduled 4:00 p.m. dose at the time LPN #7 discovered there was no documentation on the TAR. Further interview revealed LPN #7 did not remember when the LPN spoke with the agency nurse, however confirmed the LPN was aware the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 281}	Continued From page 40	{F 281}		

continued to not receive the medication after the LPN's conversation with the agency nurse. Continued interview confirmed the LPN did not follow-up with nursing administration.

Resident #29 was admitted to the facility on July 16, 2012, and readmitted to the facility on April 14, 2014, with diagnoses including Generalized Anxiety, Chronic Pain, Neuropathy, Hypertension, Chronic Obstructive Pulmonary Disease, and Gastritis.

Medical record review of hospital discharge orders dated April 14, 2014, revealed an order for "...Gabapentin (medication used to treat pain and anxiety) 600 mg PO Three times daily..." Continued review revealed an order for "...Metoclopramide (medication to aid in stomach emptying) 5 mg PO Twice daily before meals..."

Medical record review of the Physician's Orders dated April 14, 2014, through April 30, 2014, revealed no order for Gabapentin. Continued review revealed a physician's order for Metoclopramide as ordered on the hospital discharge orders.

Medical record review of the MAR dated April 14, 2014, through April 30, 2014, revealed "...Gabapentin 600 mg 1 po TID (three times daily)..." handwritten on the MAR and documented as administered from April 15, 2014, through April 22, 2014. Continued review revealed Metoclopramide was on the MAR as ordered from hospital discharge orders, however a line was drawn through the order and marked as discontinued on April 14, 2014, and documented as administered. Further review of the MAR revealed the resident continued to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

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{F 281}	Continued From page 41	{F 281}		

receive Metoclopramide from April 15, 2014, through April 20, 2014 even though the medication had been marked as discontinued, but had an order to be administered.

Medical record review of the Telephone Order/Clarification Order dated April 18, 2014, revealed a clarification order for Gabapentin 600 mg three times daily, related to the medication being on the MAR but not on the Physician's orders. Continued review revealed a clarification order dated April 18, 2014, to discontinue Metoclopramide.

Review of facility documentation entitled New Admission/Readmission Audits dated and initialed by the DON on April 15, 2014, revealed the resident's chart was audited for medication reconciliation accuracy and completed.

Interview with Nurse Consultant #1/Acting DON on April 22, 2014, at 1:07 p.m., in the Conference Room, confirmed the hospital discharge order for Gabapentin was not included on the Physician's Order sheet when sent to facility from the pharmacy. Continued interview confirmed the medication was handwritten on the MAR for April and the resident was administered the medication without an order from April 15, 2014, through April 22, 2014. Continued interview confirmed the resident's hospital discharge orders and Physician's Orders did contain an order for Metoclopramide. Further interview revealed the Nurse Consultant #1/Acting DON was uncertain why a clarification order was written on April 18, 2014, to discontinue the medication, and was uncertain why the medication was marked as discontinued on April 14, 2014. Further interview confirmed the Metoclopramide was marked as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

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{F 281}	Continued From page 42	{F 281}		

discontinued on April 14, 2014, and confirmed the resident continued to be administered the medication from April 15, 2014, through April 20, 2014. Continued interview with Nurse Consultant #1/Acting DON confirmed the resident's chart had been listed as audited and initiated as complete by the DON on April 15, 2014, and confirmed the resident's Physician's Orders and MAR continued to be incorrect after the April 15, 2014 audit by the DON.

Resident #30 was admitted to the facility on January 31, 2014, with diagnoses including Diabetes Mellitus Type II, Altered Mental State, Cerebral Palsy, Quadriplegia, and Hypertension.

Review of the March 2014 and April 2014, Physician Recapitulation sheet revealed an order for "...Accuchecks BID (two times daily) before breakfast and supper..."

Medical record review of the March and April 2014, Diabetic Medication Administration Records revealed the following:
1. No documentation of a 6:00 a.m. blood sugar obtained on March 21, 26, 28, and 29, 2014, and April 14, 2014.
2. No documentation of a 5:00 p.m. blood sugar obtained on April 15, 2014.

Interview with Nurse Consultant #1/Acting Director of Nursing, on April 22, 2014, at 4:25 p.m., in the conference room, confirmed the facility protocol was to document the blood sugar data on the Diabetic Medication Administration Record. Further interview confirmed the facility failed to follow the physician orders to obtain blood sugars twice daily in March and April 2014.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

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{F 281}	Continued From page 43	{F 281}		

Validation of the Credible Allegation of Compliance was accomplished on-site on May 13, 2014, and May 14, 2014, through medical record reviews, review of facility documents, and interviews with Nursing and Administrative Staff.

Medical record review of the closed chart of resident #3 revealed the resident's Physician Orders and Medication Administration Records were reconciled accurately on March 31, 2014. Resident #3 was discharged from the facility on April 1, 2014.

Medical record review of Resident #19's nursing notes dated April 25, 2014, revealed the Interim Director of Nursing, notified the dialysis physician and the resident's responsible party of the medication errors.

Medical record review of resident #33 revealed the resident was readmitted to the facility on May 8, 2014. Continued review of the physician orders dated May 8, 2014, revealed the orders has been verified with the physician and signed by two licensed nurses. Medical record review of the Medication Administration Record from May 8-13, 2014, revealed the resident received medications as ordered.

The facility provided evidence of audits of reconciliation of admission/re-admission orders, in-service training for all nursing staff related to physician notification of medication errors, admission/readmission physician order and medication reconciliation, medication omissions, blood glucose monitoring and shift to shift audits of accu-checks and sliding scale insulin, sliding scale insulin orders, and physician standing orders, and the pharmacy procedure for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	207 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

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(F 281)	Continued From page 44 medication orders. The facility provided documentation of an emergency Performance Improvement Meeting held on April 28, 2014, to discuss the new admission/readmission medication reconciliation process, pharmacy process, and physician notification process Interviews with Nursing Staff on all shifts May 13-14, 2014, throughout the facility, revealed the nursing staff had been in-serviced on the protocol for new admission/readmission medication order reconciliation, pharmacy protocol, medication errors, and physician standing orders. The facility will remain out of compliance at a Scope and Severity level "F" a deficient practice that constitutes no actual harm with potential for more than minimal harm, that is not Immediate Jeopardy until it provides an acceptable plan of correction and corrective actions are verified onsite.	(F 281)		
(F 309) SS=E	C/O #33583 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	(F 309)	F 309 Christian Care Center of Rutherford County believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

{F 309} Continued From page 45

This REQUIREMENT is not met as evidenced by:

Based on medical record review, review of Timeline of Events, review of Medication 3 Month Review, review of New Admission/Readmission Audits, and interview the facility failed to provide a system of quality of care to ensure any resident admitted or readmitted to the facility with hospital discharge physician's orders for medications received the correct medications. The facility's failure to provide quality of care resulted in one resident (#3) requiring re-hospitalization in critical condition, and resulted in seven residents (#19, #14 #24, #29, #13, #1, #10) receiving multiple medication errors, of thirty-one residents reviewed.

The facility's failure to reconcile hospital discharge/facility admission orders, and failure to follow up on knowledge of medication discrepancies, resulted in substandard quality of care, and is likely to place any resident admitted to the facility from the hospital in Immediate Jeopardy (a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death to a resident)

The Administrator, Regional Administrator Consultant, Assistant Director of Nursing, Nurse Consultant #1/Acting Director of Nursing, Nurse Consultant #2, Nurse Consultant #3, Vice-President of Client Operations, and Medical Director #1 were informed of the Immediate Jeopardy on April 24, 2014, at 10:55 a.m., in the Conference Room.

The Immediate Jeopardy was effective March 14,

(F 309)

Corrective Actions for Targeted Residents

Resident #3 was transferred to acute care on 3/29/14. Resident #3 returned to the facility on 3/31/14. Resident #3's medications were reconciled from the previous provider accurately on 3/31/14 by the Director of Nursing (DON). Resident #3 was discharged from the facility on 4/1/14.
Resident #24 was discharged from the facility on 4/23/14.
Resident #19's medication orders were reconciled on 4/17/14 by the DON. Resident #19's physician and family were notified of medication errors on 4/17/14 by the DON.
Resident #14's accu-check time was changed from 6 am to 7 am on 4/21/14 by the MD to be closer to mealtime. Facility protocol for sliding scale insulin administration was discontinued by the Medical Director on 4/28/14. Resident #14's family was notified on 4/21/14 by the DON of medication errors.
Resident #1 was a closed chart.
Medications for Residents #10, #13 and #29 were reconciled by the DON on 4/25/14.

Identification of Other Residents with Potential to be Affected

Current residents have the potential to be affected by this practice. A 100% audit of active residents' admission/re-admission orders from the facility-pharmacy matching the discharge orders from the previous provider, ensuring all pages were faxed to the pharmacy and reconciled correctly onto the MARs, was conducted by the DON and Nurse Consultant beginning on 4/18/14 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING: _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

(F 309) Continued From page 46

2014, and was ongoing. An extended survey was conducted on April 24, 2014.

Substandard Quality of Care was cited under F309-K

The facility provided an acceptable Allegation of Compliance on May 8, 2014, and a revist on May 13, 2014, and May 14, 2014, revealed the corrective actions implemented on May 2, 2014, removed the immediacy of the Jeopardy.

Noncompliance for F-309 continues at a "E" level citation for the facility's monitoring the effectiveness of corrective actions in order to ensure sustained compliance and evaluation of the processes by the Quality Assurance Committee.

The findings included:

Resident #3 was admitted to the facility on December 26, 2012, and readmitted to the facility on March 14, 2014, with diagnoses including Respiratory Failure, Chronic Atrial Fibrillation, Sinonal Node Dysfunction, Pneumonia, Chronic Obstructive Pulmonary Disease, Hypertension, and Cerebral Vascular Accident.

Medical record review of the hospital Discharge Med (Medication) Rec (Reconciliation) form dated March 14, 2014, revealed the hospital Discharge Med Rec form contained a total of 6 pages of medications ordered for resident #3 upon discharge from the hospital and readmission to the facility. Continued review revealed the Discharge Med Rec form for pages 1 and 2 included physician's orders for the resident to continue the following medications on

(F 309) completed on 4/22/14. The results of these admission/re-admission order audits and the actions taken by the DON and Nurse Consultant are as follows: Orders not transcribed correctly onto the MAR affected nine residents. These residents' medications were reconciled correctly onto the MAR by the Nurse Consultant on 4/22/14. Omission of medication administration doses affected two residents. The MD and family were notified of errors on 4/22/14 by the Nurse Consultant. Nursing education for licensed staff by the DON occurred on 4/22/14 regarding these errors. On 4/25/14, the DON re-wrote clarification orders for all resident charts cited for this issue by matching current orders to current MARs to ensure physician's orders are followed for accu-checks and sliding scale insulin administration and that medication reconciliation is correct. The remaining residents' medications were reconciled by the nursing staff on 4/30/14 during the MAR change-over procedure. This MAR change-over was double-checked by the Nurse Consultant on 4/29/14 and 4/30/14 to ensure accurate medication reconciliation onto new MAR. Beginning 4/22/14, the new procedure was initiated of the Consultant Pharmacist conducting a daily audit, on-site at the facility, of hospital/previous provider discharge orders to ensure accurate medication reconciliation from the previous provider was received by the pharmacy, and that all pages of admission/re-admission orders were received by the pharmacy. On-call pharmacist will conduct this audit, on-site at the facility, of medication reconciliation of new admissions/re-admissions on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

(F 309) Continued From page 47

readmission to the facility : Coumadin (blood thinner) 2.5 mg (milligrams) and 1 mg daily for a total of 3.5 mgs at 4:00 p.m., Lipitor (statin drug for cholesterol management) 10 mg at bedtime, Coreg (heart medication to regulate heart rate) 25 mg twice per day, Digoxin (heart medication to slow heart rate and control rhythm) 0.125 mg once per day, Cardizem (heart medication to control heart rate and blood pressure) 120 mg once per day, and Lisinopril (medication to control high blood pressure) 10 mg once per day.

Medical record review of Physician's Orders (recapitulation orders) for March 14, 2014, through March 31, 2014, revealed no orders for the following medications: Coumadin, Lipitor, Coreg, Digoxin, Cardizem, or Lisinopril.

Medical record review of the Medication Record (form used to document medication administration: MAR) dated March 14, 2014, through March 31, 2014, revealed two pages of medications, neither of which included the Coumadin, Lipitor, Coreg, Digoxin, Cardizem, and Lisinopril for resident #3.

Medical record review of a nurse's note dated March 30, 2014, revealed, "...Late entry for 3/28/14. At approx. (approximately) 3 p.m. this nurse was called to resident room to assess resident. Resident (#3) in bed with eyes closed, shaking et (and) c/o (complained of) being cold. Resident alert et responsive. Vital signs T (temperature) 100.8 orally, P (pulse) 138 (normal range 60-100), R (respirations) 27, B/P (blood pressure) 156/92, O2 (oxygen) 78 % (percent) via (by) nc (nasal cannula) at 3 LPM (liters per minute). This nurse instructed patient to breathe in through nose et out through mouth. O2

(F 309) weekends. This daily audit of admission/re-admission orders by the pharmacist will be on-going until desired threshold of 100% is met for three consecutive months; then quarterly. Standing Orders were revised and signed by the Medical Director on 4/28/14. Facility protocol for sliding scale insulin admini-stration was discontinued by the Medical Director on 4/28/14. Per the Medical Director's approval, sliding scale insulin administration will follow the physician's discharge orders from the hospital/previous provider. Pharmacy was notified of this revision for Standing Orders on 4/29/14 by the DON. Pharmacy staff was in-serviced regarding standing orders by Regional Director of Pharmacy on 4/28 and 4/29/14. These Standing Orders were placed in the residents' charts and in the front of the MARs by the DON on 4/29/14, who instructed each nurse when and how to use these orders and where they could be located; completed 5/1/14.

Systematic Changes

On 4/18/14, the DON initiated in-services for licensed staff regarding the new Medication Reconciliation Procedure of two nurses reconciling discharge orders from the hospital/previous provider with the physician's orders/MARs sent by the facility pharmacy with both nurses' signatures on the hospital discharge orders and the facility pharmacy MARs. In-service also included the need for the Admitting Nurse to place a telephone call to the newly-admitted resident's attending physician to review, adjust, and accept admission orders. Any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	446502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

{F 309} Continued From page 48

increased to 83%. Nurse applied a non-rebreather oxygen mask at O2 increased to 86-92% fluctuating. Nurse notified MD (medical doctor) of pt (patient) status at N/O (new order) to send to ER (emergency room) for eval (evaluation) at tx (treatment)..." Continued review revealed, "...late entry for 3/29/14 5 pm. ER staff called at stated they needed a copy of resident's MAR. This nurse faxed MAR to number provided while on phone inquiring about resident's status. No new diagnosis from hospital at this time. This nurse was informed that diagnostic testing was still being performed..."

Medical record review of a nurse's note dated April 8, 2014, timed 2:49 p.m., and signed by the Director of Nursing (DON) revealed, "...Upon chart review it is noted on the late entry dated 3-30-14 @ (at) 730 a.m., (the note is for 3-28-14) the date for the late entry is incorrect and is actually for 3-29-14 which is when this resident (#3) was transferred to the ER for further eval and treatment..."

Medical record review of Emergency Room Provider Report dated March 29, 2014, revealed resident #3 was evaluated in the emergency room. Continued review of the Emergency Room Provider Report revealed the resident had complained of shortness of breath and "...pt recently diagnosed with pneumonia...noted to be hypoxic with O2 sats (saturation, a measure of the oxygen level in the blood) in the 70's (normal range 90-100). Further review revealed the resident's vital signs were documented as blood pressure 150/50, temperature 100.3, pulse 67, and respirations 20 at 4:06 p.m. Continued review revealed, "...Cardiovascular: normal heart sounds, tachycardia (heart rate over 100),

{F 309} clarification orders given by the admitting physician will be taken by the Admitting Nurse as a telephone order and faxed to the pharmacy with the admission/re-admission orders brought by EMS/accompanied with resident. This education was ongoing by the DON until all nurses were educated, with completion by 4/29/14. 100% of facility nurses attended one of these in-services. Beginning 4/18/14, the new procedure of the DON reconciling the admission/re-admission orders daily was initiated. Newly-hired nurses and agency nurses will be educated by the DON, prior to reporting to the floor, of the new Medication Reconciliation Procedure of two nurses verifying hospital/previous provider discharge orders with orders sent by facility-pharmacy, verifying admission orders with the attending physician, and faxing to the pharmacy only the hospital/previous provider's set of orders. On 4/1/14, Pharmacy personnel was in-serviced by the Regional Director regarding verifying all numbered pages of admission/re-admission orders and calling the facility to verify number of pages faxed. On 4/15/14, Pharmacy personnel was in-serviced by the Regional Director to reconcile all orders received from the facility against the hard-copy chart orders as a final review. Beginning 4/25/14, the new procedure of the pharmacy staff at Pharmacy Office #1, home office, assuming the function of order entry to ensure initial medication reconciliation accuracy was initiated. The pharmacist at Pharmacy Office #2 will be the second check once the order is filled.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	B 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 EKON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

{F 309} Continued From page 49

irregularly irregular..." Further review revealed the resident's vital signs were documented at 5:58 p.m. "...b/p 131/80, pulse 154, resp (respirations) 26, and temp 100.3..."

Medical record review of emergency room lab report dated March 29, 2014, revealed resident #3's level of the Digoxin medication was reported as "...< (less than) 0.2 L (low)..." Continued review of the emergency room report revealed the resident had an Electrocardiogram (EKG, diagnostic test to evaluate heart rate, rhythm, and electrical pulses). Further review revealed the results of the heart monitoring test was "...A-Fib (Atrial Fibrillation) with RVR (rapid ventricular response)..." indicating the resident's heart rate and rhythm were abnormal. Continued review revealed, "...Clinical Impression: Primary Impression: Pneumonia...Secondary Impressions: AFib, COPD (Chronic Obstructive Pulmonary Disease)..." Further review revealed the resident was admitted to the hospital for further treatment.

Medical record review of Consulting Physician #1's note dated March 29, 2014, revealed resident #3 was seen by a consulting physician in the hospital. Review of the record revealed, "...Reason for Consultation: Atrial fibrillation..." Further review revealed the resident "...was found to be in atrial fibrillation with a ventricular rate around 170...(resident) has history of chronic atrial fibrillation, chronic heart failure, and had a stroke in September 2012...Currently (resident) is on long term oral anticoagulation (Coumadin)..." Further review of Consulting Physician #1's note revealed, "...Diagnostic Studies: (Resident's) EKG shows atrial fibrillation with a ventricular rate around 185, low voltage, and poor R-wave

{F 309} Beginning 4/25/14, all new orders, including admission/re-admission orders, will be reviewed by four pharmacy staff by the following procedure:

- Order entry will be performed by pharmacy technician at Pharmacy Office #1.
- Order entry/clinical review for accuracy will be conducted by the pharmacist at Office #1.
- Packaging of product will be performed by the pharmacy technician at Pharmacy Office #2.
- Final review of product and medication orders will be performed by the pharmacist at Pharmacy Office #2.

Due to Pharmacy Offices #1 and #2 being on the same computer system, this new pharmacy procedure will not impede nor slow down medication and MAR delivery to the facility. Pharmacy Office #2's pharmacy technicians and pharmacists were educated on 4/29/14 by the Vice President/Clinical Director of Pharmacy Services in person regarding the new procedure of Pharmacy Office #1 assuming the function of order entry and the procedure of orders being reviewed by four pharmacy staff, from both offices, to ensure accurate medication reconciliation from previous provider. 100% of pharmacy technicians and pharmacists were present for this in-service. No agency staff is used by Pharmacy #2. Pharmacy #1's pharmacy technicians and pharmacists were educated on 4/25/14 by the Vice President/Clinical Director of Pharmacy Services regarding the new procedure of Office #1 assuming all order entries and the procedure of orders being

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 309}	Continued From page 50 progression..." Continued review of the consultation note revealed, "...Impression: 1. Atrial fibsillation 2. Acute...chronic heart failure..." Medical record review of Consulting Physician #2's note dated March 29, 2014, revealed, "...Assessment and Plan: 1. Atrial fibrillation with rapid ventricular response. Continue Cardizem drip initiated in the emergency room...2. Pneumonia...5. Subtherapeutic digoxin level. We will load the patient with digoxin ...and repeat level in the morning hours with further orders to follow..." Medical record review of Hospitalist Physician's Progress Note dated March 30, 2014, revealed, "...Subjective: The patient (resident #3) was noted to have persistent atrial fibrillation with rapid ventricular response despite Cardizem drip. (Resident) was also noted to have hypoxia (a decreased level of oxygen in the blood)...The patient was also note (noted) to have some decreased responsiveness and (resident) was...transferred to the intensive care unit (ICU)..." Continued review of the physician's progress note revealed, "...Assessment and Plan: The patient is a 59 year old (resident) admitted to the hospital with community acquired pneumonia and atrial fibrillation with rapid ventricular response, pulmonary edema due to acute congestive heart failure exacerbation...Plan: 1. Atrial fibrillation with rapid ventricular response. Heart rate is improving. Continue Cardizem..." Medical record review of Consulting Physician #3's note dated March 30, 2014, revealed, "... (Resident #3) also has atrial fibrillation with rapid ventricular rate. (Resident) was transferred to ICU this morning because of hypoxia and also	{F 309}	reviewed by four pharmacy staff from both offices. This in-service was repeated by the Pharmacy Operations Manager on 4/29/14; this ensured 100% pharmacy technicians and pharmacists were educated. Newly-hired pharmacy technicians and pharmacists will be educated during their orientation period by the Pharmacy Operations Manager regarding new order entry system, new facility-cover sheets for faxing admission/re-admission orders to the pharmacy, and on-site daily audits of admission/re-admission orders for medication reconciliation accuracy. No agency staff is used by pharmacy #1. Beginning 4/28/14, the pharmacy will provide the facility with a cover sheet for admission/re-admission orders that will consist of a bar code that will move these orders to an "as soon as possible" status for the pharmacy. This cover sheet will also consist of nurse contact number for any clarification issues, and number of pages faxed to the pharmacy. Vice President/ Clinical Director of Pharmacy Services conducted mandatory in-services for facility licensed staff on 4/28/14 and 4/29/14 regarding utilization of the new Fax Cover Sheets for Admissions Office, new Fax Cover sheets for nurses to utilize for admissions/ re-admissions, and tips for writing and sending medication orders. 100% of facility-licensed staff attended one of these in-services. Newly-hired and agency licensed staff will be in-serviced by the DON, prior to reporting to the floor for the first time, regarding the new pharmacy cover sheet to be utilized with admission/re-admission orders to place these orders in a "priority" status for the pharmacy.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445592	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ERON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 309}	Continued From page 51	{F 309}	Monitoring	

because of persistent atrial fibrillation with rapid rate..." Continued review revealed, "...Impression: 1...Acute respiratory failure 2. Pneumonia 3. Congestive Heart Failure 4. Atrial fibrillation...Recommendations: 1. Agree with transfer to intensive care unit ...7. Continue care in the ICU, critically ill..."

Medical record review of the hospital Discharge Summary by Hospitalist Physician dated March 31, 2014, revealed, "...Hospital course: The patient (resident #3) was admitted and started on Cardizem drip...The patient did have a subtherapeutic digoxin level and the patient was loaded with digoxin. The patient was noted to have persistent atrial fibrillation with rapid ventricular response despite the Cardizem drip...The patient was transferred to the intensive care unit...Plan for this patient: 1. Pneumonia is improving...3. Atrial fibrillation with rapid ventricular response, heart rate is rate controlled. Cardizem drip has been off for over 24 hours. The patient will be discharged back to nursing home today..."

Review of Timeline of Events dated April 1, 2014, and signed by the DON, revealed: "...Timeline of Events...During MAR change-over for month ending March 2014 and beginning month April 2014, a medication error was observed. Upon investigation, it appears that resident (#3)...did not receive (resident's) scheduled Coumadin, Coreg, Digoxin, Cardizem, Lisinopril or Lipitor since (resident) was re-admitted to (facility) on 3/14/14..." Continued review of Timeline of Events revealed when the resident was readmitted to the facility on March 14, 2014, the resident's hospital discharge orders were faxed to the pharmacy. Further review of Timeline of

The results of the daily accu-check/sliding scale insulin audits will be presented by the ADON to the monthly Performance Improvement Committee for review and recommendations until desired threshold of 100% is met for three consecutive months; then quarterly. The results of the daily audits of the new Medication Reconciliation Procedure of verifying all admission/re-admission orders by two nurses, verifying admission orders with the resident's attending physician, and faxing only the orders provided by the EMS/ accompanied by the resident to the pharmacy, results of the daily on site pharmacist review of admission/re-admission orders will be presented by the DON to the monthly Performance Improvement Committee for review and recommendations until desired threshold of 100% has been met for three consecutive months; then quarterly. A Performance Improvement Committee meeting, consisting of the Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Pharmacy Consultant, Quality Assurance Nurse, and MDS Nurses was conducted on 5/22/14 and results of the above audits were found to be in continued compliance. The daily accu-checks/sliding scale insulin administration audits and the daily medication reconciliation audits will continue to be completed daily for three months as a recommendation from the Performance Improvement Committee and will continue to be reviewed monthly by the Performance Improvement Committee for recommendations regarding monitoring

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	M 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 309}	Continued From page 52 Events revealed the facility's investigation determined the pharmacy received only pages 3, 4, 5, and 6 of a total of six pages. Continued review revealed the pharmacy did not receive pages 1 and 2 which consisted of the orders for the resident's Coumadin, Coreg, Digoxin, Cardizem, Lisinopril, and Lipitor. Interview with the DON and Nurse Consultant #1 on April 15, 2014, at 2:45 p.m., in the Conference Room, revealed the DON's investigation of the medication errors revealed the nurse who faxed the resident's discharge orders from the hospital to the pharmacy did not verify with the pharmacy how many pages the pharmacy had received. Continued interview revealed when the resident's medications arrived from the pharmacy, the nurse matched the medications with the Physician Order sheets and MARS which were generated from the pharmacy, and did not reconcile the medications, or the physician orders with the hospital discharge orders. Further interview with the DON and Nurse Consultant #1 confirmed resident #3 did not receive six ordered medications (Coumadin, Coreg, Digoxin, Cardizem, Lisinopril, Lipitor) from the time of the resident's admission to the facility on March 14, 2014, until the resident's discharge to the hospital on March 29, 2014 (a total of 15 days). Further interview with the DON and Nurse Consultant #1 confirmed the facility's failure to reconcile the resident's hospital discharge orders with the facility's admission orders placed the resident at risk for serious harm, and confirmed the facility neglected the resident's physical status by not administering prescribed medications. Interview with the DON on April 16, 2014, at 12:40 p.m., in the Conference Room, confirmed	{F 309}	frequency, adjustments to monitoring, and/or system changes. The Administrator and DON will follow-up on recommendations from the Performance Improvement Committee to assure continued compliance. The Performance Improvement Committee consists of the Administrator, Medical Director, Business Office Manager, Director of Nursing, Assistant Director of Nursing, Human Resources Clerk, Clinical Records Clerk, Marketing/Admissions Director, MDS Coordinator, Assessment Nurse, Director of Activities, Director of Dietary, Director of Housekeeping/Laundry, Maintenance Director, Director of Social Services, Therapy Manager, Consultant Pharmacist, and Line-Staff Nurse.	5/22/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

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(F 309)	Continued From page 53	(F 309)		

the DON had questioned the admitting nurse of resident #3 about the resident not being admitted from the hospital with Coumadin orders. Continued interview with the DON confirmed the DON also did not reconcile the hospital discharge orders with the facility's admission orders at the time the DON became aware on March 16, 2014, the resident was not receiving Coumadin.

Interview with Hospitalist Physician #1 on April 21, 2014, at 10:26 a.m., by phone, confirmed the physician was one of resident #3's treating physicians. Further interview revealed, "...I would say the fact that (resident) did not receive medications led to the (resident's) hospitalization..." Continued interview confirmed the resident's Digoxin level "...was very low...", subtherapeutic, and confirmed the resident was "...critically ill..," necessitating the resident's transfer to the Intensive Care Unit (ICU). Further interview with Hospitalist Physician #1 confirmed when resident #3 was administered the resident's ordered medications (specifically Cardizem and Digoxin) the resident improved, and was able to be discharged back to the facility.

The facility nursing staff's failure to reconcile hospital discharge orders with facility admission orders resulted in resident #3 not receiving scheduled medications (Coumadin, Lipitor, Coreg, Digoxin, Cardizem, Lisinopril) from the day of the resident's readmission to the facility on March 14, 2014, until discharge to the hospital on March 29, 2014 (a total of 15 days), resulted in a lack of quality of care. The facility's failure to ensure the resident received prescribed medications placed resident #3 in Immediate Jeopardy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(F 309)	Continued From page 54 Resident #19 was admitted to the facility on February 26, 2014, and readmitted to the facility on March 27, 2014, with diagnoses including Acute Edema, Hypertension, Chronic Kidney Disease, Heart Disease, End Stage Renal Disease, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Parkinson's Disease, and Dementia. Medical record review of the hospital Discharge Med Rec form dated March 27, 2014, revealed no order for PhosLo (Calcium Acetate) 667 mg, a medication used to bind with phosphorus in the body to decrease the level of phosphorus in the blood). Continued review also revealed no order for Crestor 20 mg (an antistatin medication used to lower cholesterol). Further review of the Discharge Med Rec form revealed orders for Mirtazapine 7.5 mg (an antidepressant medication) and Protonix 40 mg (a stomach medication used to control acid in the stomach). Medical record review of Physician's Orders (Recapitulation orders) dated March 27, 2014, through March 31, 2014, revealed a medication order for "...Calc (calcium) Acetate Cap 667 mg 1 capsule PO (by mouth) with meals...For PhosLo..." Continued review of Physician's Orders revealed a medication order for "...Crestor tab 20 mg 1 tablet PO at bedtime..." Further review of the Physician's Orders for March 27, 2014, through March 31, 2014, revealed no medication orders for Mirtazapine (Remeron) or Protonix. Medical record review of the dated March 27, 2014, through March 31, 2014, revealed resident #19 received both Calcium Acetate and Crestor March 28, 2014, through March 31, 2014.	(F 309)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(F 309)	Continued From page 55	(F 309)		

Continued review of the MAR revealed the resident was not administered Mirtazapine or Protonix.

Medical record review of the April 1, 2014, through April 31, 2014, Physician's Orders and MARS revealed the pharmacy had included the orders for Mirtazapine and Protonix which had originally been omitted from the resident's readmission to the facility on March 27, 2014. Continued review of the Physician's Orders and MARS for April 2014, revealed nursing discontinued these medications during reconciliation of the March 27, 2014, Physician's Orders with the April, 2014 Physician's Orders provided by the pharmacy. Further review of the April Physician's Orders and MARS revealed no orders for the Calcium Acetate or Crestor (which had been omitted by pharmacy from the original hospital discharge orders and Physician's Orders March 27, 2014). Further review of the April Physician's Orders and MARS revealed nursing changed the orders to match the March 27, 2014 Physician's orders and MARS which had been added by the pharmacy in error. Therefore resident #19 continued to be administered two medications without an order (Calcium Acetate and Crestor), and failed to be administered two medications (Mirtazapine and Protonix) which had been ordered by the discharging hospital from March 27, 2014, through April 17, 2014.

Medical record review of Medication Reviews 3 Month Review dated April 4, 2014, revealed "... (Facility) Medication Reviews 3 Month Review...3-27-14 re-admit... pharmacy omitted...Protonix...Remeron (Mirtazapine), the pharmacy also added Crestor and Phoslo (Calcium Acetate) without an order. This was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(F 309)	Continued From page 56	(F 309)		

caught by nursing. The April POS (Physician's orders) from the pharmacy was correct however when the nurse checked the POS (Physician's orders) (the nurse) changed all the orders to match March's MAR..." Further review of facility documentation revealed the Medication Reviews 3 Month Review was sent by email from Nurse Consultant #1 to the Director of Nursing (DON) and Administrator on April 4, 2014.

Interview with the DON and Nurse Consultant #1 on April 17, 2014, at 2:55 p.m., in the Conference Room, confirmed the resident's March 2014 and April 2014 Physician's orders and MARs were incorrect. Continued interview confirmed the resident continued to receive discontinued medications, PhosLo (Calcium Acetate) and Crestor without a physician's order, and confirmed the resident did not receive ordered medications Mirtazapine and Protonix from March 27, 2014, until April 17, 2014. Further interview confirmed both the DON and Nurse Consultant #1 became aware the resident was receiving medications that were not ordered, and became aware the resident was not receiving ordered medications on April 4, 2014, and confirmed both neglected to correct the medication errors, and the resident continued to receive Calcium Acetate and Crestor without physician orders, and did not receive ordered medications, Mirtazapine and Protonix, through April 17, 2014.

The failure of the facility nursing staff to accurately reconcile hospital discharge orders with facility admission orders, and the facility's nursing and nursing management staff's failure to act on knowledge of the medication errors upon discovery of the errors, resulted in a lack of quality of care, and placed resident #19 in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(F 309)	Continued From page 57 Immediate Jeopardy.	(F 309)		

Resident #14 was admitted to the facility on March 31, 2014, discharged to the hospital on April 1, 2014, related to care for a cyst, and readmitted to the facility on April 11, 2014, with diagnoses including Diabetes Mellitus, Hypertension, Peripheral Neuropathy, Congestive Heart Failure, and Acute Renal Failure.

Medical record review of the physician order dated March 31, 2014, revealed "...Accucheck (monitoring of blood sugar) AC + HS (before meals and bedtime)..."

Medical record review revealed no documentation of the monitoring of the blood sugar level before the supper meal on March 31, 2014.

Medical record review of the hospital Discharge Med Rec dated April 10, 2014, for the facility readmission on April 11, 2014, revealed an order for sliding scale insulin (SSI). The facility readmission orders dated April 11, 2014, revealed the hospital SSI order reverted to the facility SSI protocol (effective on September 2012) as follows "Novolin R (fast acting insulin, medication to control blood sugar) inject subcutaneously (under the skin) as directed per SSI (Sliding Scale Insulin): If glucose (blood sugar) < (less than) 60 give snack & (and) recheck in 30 minutes. If recheck still <60 give Glucagon UD (Unit Dose); 251-300= 4 units (give 4 units); 301-350=6 units. 351-400=8 units; 401-450= 10 units; Recheck in 1HR (hour) using above sliding scale if BG (Blood Glucose) > (greater than) 300; >450= (means) call MD (physician) for orders recheck in 1 HR or per MD..." Further review of the readmission

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(F 309)	Continued From page 58	(F 309)		

orders revealed "...Accucheck AC + HS..."

Medical record review of the Diabetic Medication Administration Record dated April 2014, revealed the accuchecks were to be completed at 6:00 a.m. (morning); 11:00 a.m.; 5 p.m. (evening); and 9 p.m. Further review of the form revealed the following:
1. April 18, 2014, at 5:00 p.m. the accucheck was 253 and no documentation of the insulin administration (should have administered 4 units);
2. April 19, 2014, at 5:00 p.m. the accucheck was 301 and no insulin administration (should have administered 6 units);
3. April 19, 2014, at 9:00 p.m. no accucheck was obtained;
4. April 20, 2014, at 11:00 a.m. the accucheck was 305 and no insulin administration (should have administered 6 units);
5. April 21, 2014, before the breakfast meal, no accucheck was obtained, and on
6. April 23, 2014, at "6A (6:00 a.m.)" no accucheck was obtained.

Interview with Licensed Practical Nurse (LPN) #1 assigned to resident #14, on April 21, 2014, at 11:15 a.m., on the 100 hall revealed "...the night nurse (7:00 p.m. to 7:00 a.m. shift) obtains the blood sugar..." Further interview confirmed the blood sugar level for April 21, 2014, at 6:00 a.m. was not documented on the Diabetic Medication Administration Record.

Interview with Nurse Consultant #1/Acting Director of Nursing, on April 21, 2014, at 11:38 a.m., in the Conference Room confirmed the blood sugar level and the insulin administration when the blood sugar was elevated was to be documented on the Diabetic Medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(F 309)	Continued From page 59	(F 309)		

Administration Record. Further interview and review of the April 2014 Diabetic Medication Administration Record confirmed the facility nursing staff failed to obtain blood sugar levels and failed to administered the insulin when the blood sugar was elevated.

Interview with Medical Director #2, on April 21, 2014, at 11:52 a.m., in the Conference Room confirmed "...expect (resident #14) should have gotten sliding scale (insulin) per order (when blood sugar elevated)..."

Interview with LPN #5, on April 23, 2014, at 7:45 a.m., at the 200/300 nursing station, and Nurse Consultant #1/Acting Director of Nursing present, confirmed LPN #5 had been responsible for resident #14 during the 7:00 p.m.-7:00 a.m. shift and had not obtained the blood sugar level the morning of April 23, 2014.

Interview with LPN #4, and observation on April 23, 2014, at 7:50 a.m., and Nurse Consultant #1/Acting Director of Nursing present, outside the room of resident #14, confirmed LPN #4 was responsible for resident #14 for the 7:00 a.m.-7:00 p.m. shift, and had not obtained the blood sugar the morning of April 23, 2014. When LPN #4 was asked which shift was responsible to obtain the morning blood sugar LPN #4 stated "...the night shift (7:00 p.m.-7:00 a.m.) does it." Further interview with the Nurse Consultant #1/Acting Director of Nursing revealed this surveyor "...got to (LPN #4) before the Nurse Consultant #1/Acting Director of Nursing could in-service (LPN #4) (on the change in the accucheck time before the breakfast meal)..."

Interview with Nurse Consultant #1, on April 23,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 309}	Continued From page 60	{F 309}		

2014, at 1:20 p.m., in the Conference Room, confirmed the facility had failed to inservice LPN #4 regarding the change in the accucheck time from 6:00 a.m. to 7:00 a.m.

Interview with LPN #8 and Nurse Consultant #2, on April 24, 2014, at 10:15 a.m., at the 100/200 nursing station, confirmed resident #14 had been admitted on March 31, 2014, at 2:50 p.m. and had been discharged before breakfast on April 1, 2014. Further interview confirmed the accucheck for March 31, 2014, at 5:00 p.m. was not obtained.

The facility's nursing staff failure to monitor the blood sugar level and the nursing staffs failure to administer the prescribed insulin when the blood sugar was elevated placed resident #14 in Immediate Jeopardy.

Review of the hospital Discharge Medication Reconciliation dated April 10, 2014, for the facility readmission on April 11, 2014, for resident #14 included an order for "...Gabapentin (medication to treat nerve pain) 800 mg (milligrams) po (by mouth) every 6 hours..."

Medical record review of the facility readmission orders dated April 11, 2014, and the April 11-30, 2014, MAR documentation revealed the pharmacy failed to transcribe the Gabapentin 800 mg po every 6 hours onto the MAR.

Interview with Nurse Consultant #1, on April 17, 2014, at 2:20 p.m., in the Conference Room, confirmed the facility nursing staff had failed to reconcile the hospital discharge medications with the facility readmission orders, a standard of quality care. Further interview confirmed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 309}	Continued From page 61	{F 309}		

Director of Nursing had conducted an audit upon readmission on April 11, 2014, to review the medication reconciliation and had failed to identify the omission of the Gabapentin order for resident #14.

Interview with Pharmacist #1 on April 22, 2014, at 1:25 a.m., in the conference room, , revealed the facility identified a breakdown in communication between the pharmacy and the facility in early April.
Further interview revealed prior to the last Performance Improvement meeting held April 10, 2014, the pharmacy did not compare/reconcile hospital discharge medication to the facility admission physician orders. Further interview revealed "...assumed orders verified prior to contact with (pharmacy) or that the nursing facility made a clarification order prior to contacting the (Pharmacy)..."

Resident #24 was admitted to the facility on April 2, 2014, with diagnoses including Anemia, Dementia, Parkinson's Disease, and Chronic Kidney Disease Stage 3.

Medical record review of the hospital discharge orders dated April 2, 2014, revealed a medication order for "...Melatonin (herbal medication prescribed for sleep) 4 mg daily at 1800 (6:00 p.m.)...Latuda (an atypical antipsychotic medication prescribed for anxiety) 20 mg Twice daily with meals...Latuda 10 mg every 6 hours as needed...for anxiety..."

Medical record review of the Physician's Orders dated April 2, 2014, through April 30, 2014, revealed an order for "...Melatonin 5 mg 1 tab (tablet) PO at 8 p.m..." Continued review of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 309}	Continued From page 62	{F 309}		

Physician Orders revealed no order for Latuda.

Medical record review of the MAR dated April 2, 2014, through April 30, 2014, revealed resident #24 was administered Melatonin 5 mg from April 4, 2014, through, April 20, 2014. Continued review of the MAR revealed Latuda 20 mg twice a day and Latuda 10 mg every 6 hours as needed was handwritten on the form. Further review revealed the resident was administered Latuda 20 mg twice a day from April 3, 2014, through April 8, 2014, and was administered Latuda 10 mg April 4, 2014, through April 7, 2014, one time daily .

Review of the facility documentation entitled New Admission/Readmission Audits dated April 3, 2014, revealed resident #24's admission orders had been listed as audited and initialed by the DON as being completed and correct.

Interview with Nurse Consultant #1/Acting DON on April 21, 2014, at 4:05 p.m., in the Conference Room, confirmed the Physician Orders and the MAR had the wrong dose of Melatonin and did not match the discharge orders from the hospital. Further interview confirmed the resident was administered the wrong dose of Melatonin from April 2, 2014, through April 20, 2014. Continued interview confirmed the MAR included medication administration of Latuda 20 mg April 3, 2014, through April 8, 2014, and Latuda 10 mg April 4, 2014, through April 7, 2014. Further interview confirmed Latuda was not on the Physician's Order for April 2014, and the resident received the medication without a physician's order. Further interview with Nurse Consultant #1/Acting DON confirmed the resident's hospital discharge orders and admission orders were documented

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 309}	Continued From page 63	{F 309}		

as being audited and correct by the DON. Continued interview confirmed the resident's medications continued to be incorrect after the audit and the facility had failed to provided quality of care standards with medication administration.

Resident #29 was admitted to the facility on July 16, 2012, and readmitted to the facility on April 14, 2014, with diagnoses including Generalized Anxiety, Chronic Pain, Neuropathy, Hypertension, Chronic Obstructive Pulmonary Disease, and Gastritis.

Medical record review of hospital discharge orders dated April 14, 2014, revealed an order for "...Gabapentin (medication used to treat pain and anxiety) 600 mg PO Three times daily..." Continued review revealed an order for "...Metoclopramide (medication to aid in stomach emptying) 5 mg PO Twice daily before meals..."

Medical record review of the Physician's Orders dated April 14, 2014, through April 30, 2014, revealed no order for Gabapentin. Continued review revealed a physician's order for Metoclopramide as ordered on hospital discharge orders.

Medical record review of the MAR dated April 14, 2014, through April 30, 2014, revealed "...Gabapentin 600 mg 1 po TID..." handwritten on the MAR. Continued review revealed Metoclopramide was on the MAR as ordered from hospital discharge orders, however a line was drawn through the order and marked as discontinued on April 14, 2014. Further review of the MAR revealed resident #29 continued to receive Metoclopramide April 15, 2014, through April 20, 2014 even though the medication had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(F 309)	Continued From page 64	(F 309)		

been marked as discontinued, but had an order to be administered.

Medical record review of the Telephone order/Clarification order dated April 18, 2014, revealed a clarification order for Gabapentin 600 mg three times daily, related to the medication being on the MAR but not on the Physician's orders. Continued review revealed a clarification order dated April 18, 2014, to discontinue Metoclopramide.

Review of facility documentation entitled New Admission/Readmission Audits dated and initiated by the DON on April 15, 2014, revealed the resident's chart was audited for medication reconciliation accuracy and completed.

Interview with Nurse Consultant #1/Acting DON on April 22, 2014, at 1:07 p.m., in the Conference Room, confirmed the hospital discharge order for Gabapentin was not included on the Physician's Order sheet when sent to facility from the pharmacy. Continued interview confirmed the medication was handwritten on the MAR for April and the resident was administered the medication without an order from April 15, 2014, through April 22, 2014. Continued interview confirmed the resident's hospital discharge orders and Physician's Orders did contain an order for Metoclopramide. Further interview revealed the Nurse Consultant #1/Acting DON and was uncertain why a clarification order was written on April 18, 2014, to discontinue the medication, and was uncertain why the medication was marked as discontinued on April 14, 2014. Further interview confirmed the Metoclopramide was marked as discontinued on April 14, 2014, and confirmed the resident continued to be administered the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

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(F 309)	Continued From page 65	(F 309)		

medication from April 15, 2014, through April 20, 2014. Continued interview with Nurse Consultant #1/Acting DON confirmed the resident's chart had been listed as audited and initialed as complete by the DON on April 15, 2014, and confirmed the resident's Physician's Orders and MAR continued to be incorrect after the April 15, 2014 audit by the DON.

Resident #13 was admitted to the facility on February 24, 2014, and readmitted to the facility on March 25, 2014, with diagnoses including Aftercare for Joint Replacement, Hyperlipidemia, Hypertension, Muscle Weakness, and Lack of Coordination.

Medical record review of hospital Medication Discharge Report dated February 24, 2014, revealed an order for Cranberry Liquid Supplement, once every day.

Medical record review of Physician's Orders dated February 24, 2014, through February 28, 2014, revealed no order for Cranberry Liquid Supplement.

Medical record review of Medication Record (MAR) dated February 24, 2014, through February 28, 2014, revealed the resident did not receive Cranberry Liquid Supplement for that time period.

Medical record review of the hospital Medication Discharge Report dated March 25, 2014, revealed an order for "...aspirin 325 mg (milligrams), by mouth, twice daily..." Continued review revealed an order for Cranberry Liquid Supplement, once every day.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

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(F 309)	Continued From page 66 Medical record review of the Physician's Orders dated March 25, 2014, through March 31, 2014, revealed no order for aspirin. Continued review of the Physician Orders revealed an order "...Cranberry liquid Supplement take PO (by mouth) QD (every day)..." Medical record review of the Medication Record (MAR) dated March 25, 2014, through March 31, 2014, revealed a handwritten notation for "...ASA (aspirin) 325 mg 1 PO BID (twice daily)..." Continued review of the MAR revealed resident #13 was administered the aspirin March 26, 2014, through March 31, 2014. Further review of the MAR revealed the Cranberry Liquid Supplement was on the MAR, however was not given March 26, 2014, through March 31, 2014. Interview with Nurse Consultant #1 on April 17, 2014, at 9:50 a.m., in the Conference Room, confirmed the resident's Physician Orders and MARs were not complete, and the resident did not receive the Cranberry Supplement as ordered for February 24, 2014, through February 28, 2014. Continued interview confirmed the hospital discharge records for March 25, 2014, included an order for Aspirin 325 mg, and confirmed the Physician Order sheets for March 25, 2014, through March 31, 2014, did not contain an order for Aspirin. Further interview confirmed the MAR for the same time period had Aspirin handwritten on the MAR, and confirmed the resident had received Aspirin March 26, 2014, through March 31, 2014, without a facility physician order. Continued interview with Nurse Consultant #1 confirmed the resident had an order for Cranberry Supplement, and confirmed the cranberry supplement had not been administered as ordered March 26, 2014, through March 31,	(F 309)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 67	F 309		

2014.

Resident #1 was admitted to the facility on March 11, 2014, with diagnoses including Diabetes Mellitus Type II, Morbid Obesity, Hypertension, and Peripheral Vascular Disease.

Medical record review of a nursing note dated March 25, 2014, revealed the resident was discharged from the facility on March 25, 2014.

Medical record review of the hospital Discharge Report dated March 11, 2014, revealed an order for "...Metoprolol (blood pressure medication) 12.5 mg (milligrams) by mouth, twice daily..."

Medical record review of the facility March 11, 2014, admission orders and the March 11-25, 2014, Medication Record (MAR documentation of medication administration) revealed Metoprolol was not included.

Interview with the Director of Nursing and Nurse Consultant #1, on April 15, 2014, at 2:35 p.m., in the Conference Room, confirmed the facility nursing staff failed to accurately reconcile the hospital discharge orders with the facility admission orders for Metoprolol, per standard of practice, from the Admission on March 11, 2014 through the discharge on March 28, 2014.

Resident #10 was admitted to the facility on March 28, 2014, and readmitted to the facility on April 9, 2014, with diagnoses including Diabetes Mellitus Type II, Arteriosclerotic Dementia, Major Depressive Disorder, Anxiety, and Affective Psychoses.

Medical record review of the hospital discharge

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(F 309)	Continued From page 68	(F 309)		

medications dated March 27, 2014, revealed an order for "...lubricating top (topical) jelly bacteriostatic apply small amount to affected area two times a day as needed..."

Medical record review of the March 28, 2014, facility admission orders and the Medication Record (MAR documentation of medication administration) revealed no documentation for the order of lubricating top jelly bacteriostatic.

Interview with Nurse Consultant #1, on April 17, 2014, at 8:45 a.m., in the Conference Room confirmed the facility nursing staff failed to accurately reconcile the hospital discharge order with the facility admission order, per standard of practic, for the March 28, 2014, admission.

Interview with Pharmacist #1, on April 22, 2014, beginning at 1:25 p.m., in the Conference Room confirmed the lubricating jelly was "...a blatant omission by pharmacy..."

Validation of the Credible Allegation of Compliance was accomplished on-site on May 13, 2014, and May 14, 2014, through medical record reviews, review of facility documents, and interviews with Nursing and Administrative Staff.

Medical record review of the closed chart of resident #3 revealed the resident's Physician Orders and Medication Administration Records were reconciled accurately on March 31, 2014. Resident #3 was discharged from the facility on April 1, 2014.

Medical record review of resident #33 revealed the resident was readmitted to the facility on May 6, 2014. Continued review of the physician orders

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(F 309)	Continued From page 69	{F 309}		

dated May 8, 2014, revealed the orders has been verified with the physician and signed by two licensed nurses. Medical record review of the Medication Administration Record from May 8-13, 2014, revealed the resident received medications as ordered.

The facility provided evidence of audits of reconciliation of admission/re-admission orders, in-service training for all nursing staff related to physician notification of medication errors, admission/readmission physician order and medication reconciliation, medication omissions, blood glucose monitoring and shift to shift audits of accu-checks and sliding scale insulin, sliding scale insulin orders, and physician standing orders, and the pharmacy procedure for medication orders.

The facility provided documentation of an emergency Performance Improvement Meeting held on April 28, 2014, to discuss the new admission/readmission medication reconcilation process, pharmacy process, and physician notification process.

Interviews with Nursing Staff on all shifts May 13-14, 2014, throughout the facility, revealed the nursing staff had been in-serviced on the protocol for new admission/readmission medication order reconciliation, pharmacy protocol, medication errors, and physician standing orders.

The facility will remain out of compliance at a Scope and Severity level "E" a pattern of deficient practice that constitutes no actual harm with potential for more than minimal harm, that is not Immediate Jeopardy until it provides an acceptable plan of correction and a revisit verifies

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	702 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

{F 309} Continued From page 70
corrective actions onsite.

C/O #33583

{F 333} SS=F 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS

The facility must ensure that residents are free of any significant medication errors.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, review of Timeline of Events, and interview, the facility failed to reconcile hospital discharge orders with facility admission orders for one resident (#3), and failed to monitor the accuchecks and provide insulin for elevated blood sugars for one resident (#14) of thirty-one sampled residents reviewed, resulting in significant medication errors. The failure of the facility to reconcile the medication orders placed resident #3 in Immediate Jeopardy, and the facility's failure to monitor and administer insulin as ordered, placed resident #14 in Immediate Jeopardy (a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident).

The Administrator, Regional Administrator Consultant, Assistant Director of Nursing, Nurse Consultant #1/Acting Director of Nursing, Nurse Consultant #2, Nurse Consultant #3, Vice-President of Client Operations, and Medical Director #1 were informed of the Immediate Jeopardy on April 24, 2014, at 10:55 a.m., in the Conference Room.

{F 309}

{F 333} F 333

Christian Care Center of Rutherford County believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:

Corrective Actions for Targeted Residents

Resident #3 was transferred to acute care on 3/29/14. Resident #3 returned to the facility on 3/31/14. Resident #3's medications were reconciled from the previous provider accurately on 3/31/14 by the Director of Nursing. Resident #3 was discharged from the facility on 4/1/14.
Resident #14's accu-check time was changed from 6 am to 7 am on 4/21/14 to be closer to mealtime. Facility protocol of sliding scale insulin administration was removed from the Standing Orders by the Medical Director on 4/28/14. Resident #14's family was notified of medication errors by the Director of Nursing on 4/21/14.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 UNION SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

{F 333} Continued From page 71

The Immediate Jeopardy was effective March 14, 2014, and was ongoing.

An extended survey was conducted on April 24, 2014

Substandard Quality of Care was cited at F333-L.

The facility provided an acceptable Allegation of Compliance on May 8, 2014, and a revist on May 13, 2014, and May 14, 2014, revealed the corrective actions implemented on May 2, 2014, removed the Immediacy of the Jeopardy.

Noncompliance for F-333 continues at a "F" level citation for the facility's monitoring the effectiveness of corrective actions in order to ensure sustained compliance and evaluation of the processes by the Quality Assurance Committee.

The findings included;

Resident #3 was admitted to the facility on December 26, 2012, and readmitted to the facility on March 14, 2014, with diagnoses including Respiratory Failure, Chronic Atrial Fibrillation, Sinonal Node Dysfunction, Pneumonia, Chronic Obstructive Pulmonary Disease, Hypertension, and Cerebral Vascular Accident.

Medical record review of the hospital Discharge Med (Medication) Rec (Reconciliation) form dated March 14, 2014, revealed the hospital Discharge Med Rec form contained a total of 6 pages of medications ordered for the resident upon discharge from the hospital and readmission to the facility. Continued review revealed the

{F 333} Identification of Other Residents with Potential to be Affected

Residents receiving medications from the facility have the potential to be affected by this practice; to include newly-admitted and re-admitted residents receiving accu-checks and sliding scale insulin. A 100% audit of active residents' admission/re-admission orders from the facility-pharmacy matching the discharge orders from the previous provider, ensuring all pages were faxed to the pharmacy and reconciled correctly onto the MARs, was conducted by the DON and Nurse Consultant beginning on 4/18/14 and completed on 4/22/14. The results of these admission/re-admission order audits and the action taken by the DON and Nurse Consultant are as follows: orders not transcribed correctly onto the MAR affected nine residents. These residents' medications were reconciled correctly onto the MAR by the Nurse Consultant on 4/22/14. Omission of medication administration doses affected two residents. MD and family were notified of errors on 4/22/14 by the Nurse Consultant. Nursing education of licensed staff by the DON occurred regarding these errors on 4/22/14. Also, on 4/25/14, the DON re-wrote clarification orders for all resident-charts cited for this issue by matching current orders to current MARs to ensure physician's orders are followed for accu-checks and sliding scale insulin and that medication reconciliation is correct. The remaining residents' medications were reconciled by the Nursing Staff on 4/30/14 during MAR change-over procedure.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

{F 333} Continued From page 72

Discharge Med Rec form for pages 1 and 2 included physician's orders for the resident to continue the following medications on readmission to the facility: Coumadin (blood thinner) 2.5 mg (milligrams) and 1 mg daily for a total of 3.5 mgs at 4:00 p.m., Lipitor (statin drug for cholesterol management) 10 mg at bedtime, Coreg (heart medication to regulate heart rate) 25 mg twice per day, Digoxin (heart medication to slow heart rate and control rhythm) 0.125 mg once per day, Cardizem (heart medication to control heart rate and blood pressure) 120 mg once per day, and Lisinopril (medication to control high blood pressure) 10 mg once per day.

Medical record review of Physician's Orders (recapitulation orders) for March 14, 2014, through March 31, 2014, revealed no orders for the following medications: Coumadin, Lipitor, Coreg, Digoxin, Cardizem, or Lisinopril.

Medical record review of the Medication Record (form used to document medication administration: MAR) dated March 14, 2014, through March 31, 2014, revealed two pages of medications, neither of which included the Coumadin, Lipitor, Coreg, Digoxin, Cardizem, and Lisinopril.

Medical record review of nurse's note dated March 30, 2014, (documented incorrectly, the actual date of event is March 29, 2014, as documented in a late entry note by the DON on April 8, 2014), revealed the resident was transferred to the hospital to be evaluated and treated in the emergency room.

Medical record review of emergency room notes, and physician's progress notes dated March 29,

{F 333} This MAR change-over was double-checked by the Nurse Consultant on 4/29/14 and 4/30/14 to ensure accurate medication reconciliation onto new MAR. Beginning 4/22/14, the new procedure was initiated of two nurses reconciling discharge orders from the hospital/previous provider with the physician's orders/MARs sent by the facility pharmacy with both nurses' signatures on both the hospital discharge orders and the MARs sent by the facility-pharmacy. The Admitting Nurse will call the newly-admitted resident's attending physician to review, adjust, and accept admission orders. Any clarification orders given by the admitting physician will be taken by the Admitting Nurse as a telephone order and faxed to the pharmacy with the admission/re-admission orders brought by EMS/accompanied by the resident. Upon investigation, it was discovered the root cause of this issue was that more than one set of admission/re-admission orders from the previous provider were being faxed to the pharmacy, and that not all pages of admission orders were being faxed to the pharmacy. Beginning 4/18/14, only one set of admission/re-admission orders brought by EMS/accompanied by the resident will be faxed to the pharmacy to avoid this confusion.

Systematic Changes

Standing Orders were revised and signed by the Medical Director on 4/28/14. Facility protocol for sliding scale insulin administration was discontinued by the Medical Director on 4/28/14. Per the Medical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

{F 333} Continued From page 73

2014, revealed resident #3 was treated in the emergency department for Atrial Fibrillation. Continued review revealed emergency room lab reports which documented the resident's digoxin level was "< 0.2 L", subtherapeutic. Further review revealed the resident was documented as "critically ill" and was admitted to the Intensive Care Unit (ICU) of the hospital.

Medical record review of a physician's discharge summary dated March 31, 2014, revealed the resident was stabilized in the ICU after the resident received Cardizem and Digoxin (two of the medications which had been omitted from the facility's physician's orders).

Interview with Hospitalist Physician #1 on April 21, 2014, at 10:26 a.m., by phone, confirmed the Physician was the resident's treating physician in the hospital. Continued interview confirmed the resident's digoxin "was very low" and the resident was "critically ill" when admitted to the ICU. Further interview confirmed when the resident was administered Digoxin and Cardizem the resident was stabilized and able to be discharged back to the facility. Further interview revealed, "...I would say the fact that (resident) did not receive medications (Digoxin, Cardizem) led to the resident's hospitalization..."

Review of Timeline of Events dated April 1, 2014, and signed by the DON, revealed, "...Timeline of Events...During MAR change-over for month ending March 2014 and beginning month April 2014, a medication error was observed. Upon investigation, it appears that resident (#3)...did not receive (resident's) scheduled Coumadin, Coreg, Digoxin, Cardizem, Lisinopril or Lipitor since (resident) was re-admitted to (facility) on

{F 333} Director's approval, sliding scale insulin administration will follow the physician's discharge orders from the hospital/previous provider. Pharmacy was notified of this revision for Standing Orders on 4/29/14 by the DON. Pharmacy staff was in-serviced regarding standing orders by the Regional Director of Pharmacy on 4/28/14 and 4/29/14. These Standing Orders were placed in the residents' charts and in the front of the MARs by the DON on 4/29/14, who instructed each nurse when and how to use these orders and where they could be located; completed 5/1/14. On 4/24/14, the ADON immediately educated all nurses working both shifts that day regarding the necessity of performing accu-checks and administering sliding scale insulin as ordered by the physician. Beginning 4/24/14, these accu-check performance and sliding scale insulin administration in-services are ongoing by the ADON until all licensed staff is educated regarding following physician's orders for accu-checks and sliding scale insulin administration, with a completion date of 4/29/14. Beginning 4/22/14, the new procedure was initiated of each licensed nurse performing an accu-check performance/ sliding scale insulin administration audit every shift with oncoming nurse for accuracy and completion of documentation onto the Diabetic Flow Record. The DON/ADON will follow up on the results of these accu-check/sliding scale insulin audits on a daily basis. Nursing Supervisor will follow up on the results of these accu-check/sliding scale insulin audits on the weekends. Noncompliant issues found as a result of these audits will be reported to the Administrator and addressed by the DON with nursing education and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

{F 333} Continued From page 74

3/14/14..." Continued review of Timeline of Events revealed when the resident was readmitted to the facility on March 14, 2014, the resident's hospital discharge orders were faxed to the pharmacy. Further review of Timeline of Events revealed the facility's investigation determined the pharmacy received only pages 3, 4, 5, and 6 of a total of six pages. Continued review revealed the pharmacy did not receive pages 1 and 2 which consisted of the orders for the resident's Coumadin, Coreg, Digoxin, Cardizem, Lisinopril, and Lipitor.

Interview with the DON and Nurse Consultant #1 on April 15, 2014, at 2:45 p.m., in the Conference Room, revealed the DON's investigation of the medication errors revealed the nurse who faxed the resident's discharge orders from the hospital to the pharmacy did not verify with the pharmacy how many pages the pharmacy had received. Continued interview revealed when the resident's medications arrived from the pharmacy, the nurse matched the medications with the Physician Order sheets and MARS which were generated from the pharmacy, and did not reconcile the medications, or the physician orders with the hospital discharge orders. Further interview with the DON and Nurse Consultant #1 confirmed resident #3 did not receive six ordered medications (Coumadin, Coreg, Digoxin, Cardizem, Lisinopril, Lipitor) from the time of the resident's admission to the facility on March 14, 2014, until the resident's discharge to the hospital on March 29, 2014 (a total of 15 days). Further interview with the DON and Nurse Consultant #1 confirmed the facility's failure to reconcile the resident's hospital discharge orders with the facility's admission orders placed the resident at risk for serious harm, and confirmed the facility's

{F 333} disciplinary action as appropriate. On 4/18/14, the DON initiated in-services for licensed staff regarding the new Medication Reconciliation Procedure of two nurses reconciling discharge orders from the hospital/previous provider with the physician's orders/MARs sent by the facility pharmacy with both nurses' signatures on the hospital discharge orders and the facility pharmacy MARs. In-service also included verifying admission orders with the newly-admitted resident's attending physician and faxing orders brought by EMS/accompanied by the resident to the pharmacy. This education was ongoing by the DON until all nurses were educated, with completion by 4/29/14. Beginning 4/18/14, the new procedure of the DON reconciling the admission/re-admission orders daily was initiated. Newly-hired nurses and agency nurses will be educated by the DON, prior to reporting to the floor for the first time, of the new Medication Reconciliation Procedure of two nurses verifying hospital/previous provider discharge orders with orders sent by facility-pharmacy, verifying admission orders with the resident's attending physician, and faxing only the EMS set of orders to the pharmacy. Beginning 4/22/14, the new procedure was initiated of the Consultant Pharmacist conducting a daily audit, on-site at the facility, of hospital/previous provider discharge orders to ensure accurate medication reconciliation from the previous provider was received by the pharmacy, and that all pages of admission/re-admission orders were received by the pharmacy. On-call pharmacist will conduct this audit, on-site at the facility, on medication reconciliation of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	262 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

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{F 333} Continued From page 75

failure to reconcile the medications resulted in significant medication errors.

The facility's failure to reconcile hospital discharge orders with facility admission orders resulted in significant medication errors of omission of 6 medications (Coumadin, Lipitor, Coreg, Digoxin, Cardizem, Lisinopril) prescribed for heart arrhythmia and blood pressure from March 14, 2014, through March 29, 2014 (a total of 15 days). The facility's failure to ensure the resident was free from significant medication errors resulted in Immediate Jeopardy for resident #3.

Resident #14 was admitted to the facility on March 31, 2014, discharged to the hospital on April 1, 2014, related to care for a cyst, and readmitted to the facility on April 11, 2014, with diagnoses including Diabetes Mellitus, Hypertension, Peripheral Neuropathy, Congestive Heart Failure, and Acute Renal Failure.

Medical record review of the physician order dated March 31, 2014, revealed "...Accucheck (monitoring of blood sugar) AC + HS (before meals and bedtime)..."

Medical record review revealed no documentation of the monitoring of the blood sugar level before supper for March 31, 2014.

Medical record review of the hospital Discharge Med Rec dated April 10, 2014, for the facility readmission on April 11, 2014, revealed an order for sliding scale insulin (SSI). The facility readmission orders dated April 11, 2014, revealed the hospital SSI order reverted to the facility SSI

{F 333}

new admissions/re-admissions on the weekends. This daily audit of admission/ re-admission orders by the pharmacist will be on-going until desired threshold of 100% is met for three consecutive months; then quarterly. Newly-hired nurses and agency nurses will be educated by the DON, prior to reporting to the floor for the first time, of the new Medication Reconciliation Procedure of two nurses verifying new admission/re-admission orders and faxing orders brought by EMS/ accompanied by the resident to the pharmacy. Newly-hired and agency nurses will also be educated during their orientation period by the DON regarding the need to perform accu-checks and administer sliding scale insulin as ordered by the physician.
On 4/1/14, Pharmacy Personnel were in-serviced by the Regional Director regarding verifying all numbered pages of admission/re-admission orders and calling the facility to verify number of pages faxed. Beginning 4/25/14, the new procedure was initiated of the pharmacy staff at Pharmacy Office #1, home office, assuming the function of order entry to ensure initial medication reconciliation accuracy. The pharmacist at Pharmacy Office #2 will be the second check once the order is filled. Beginning 4/25/14, all new orders, including admission/re-admission orders, will be reviewed by four pharmacy staff by the following procedure:

- Order entry will be performed by pharmacy technician at Pharmacy Office #1.
- Order entry/clinical review for accuracy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

{F 333} Continued From page 76

protocol (effective on September 2012) as follows "Novolin R (fast acting insulin, medication to control blood sugar) inject subcutaneously (under the skin) as directed per SSI (Sliding Scale Insulin); If glucose (blood sugar) < (less than) 60 give snack & (and) recheck in 30 minutes. If recheck still <60 give Glucagon UD (Unit Dose); 251-300= 4 units (give 4 units); 301-350=6 units; 351-400=8 units; 401-450= 10 units; Recheck in 1HR (hour) using above sliding scale if BG (Blood Glucose) > (greater than) 300; >450= (means) call MD (physician) for orders recheck in 1 HR or per MD..." Further review of the readmission orders revealed "...Accucheck AC + HS..."

Medical record review of the Diabetic Medication Administration Record dated April 2014, revealed the accuchecks were to be completed at 6:00 a.m. (morning); 11:00 a.m.; 5 p.m. (evening); and 9 p.m. Further review of the form revealed the following:

1. April 18, 2014, at 5:00 p.m. the accucheck was 253 and no insulin administration (should have administered 4 units);
2. April 19, 2014, at 5:00 p.m. the accucheck was 301 and no insulin administration (should have administered 6 units);
3. April 19, 2014, at 9:00 p.m. no accucheck was obtained;
4. April 20, 2014, at 11:00 a.m. the accucheck was 306 and no insulin administration (should have administered 6 units);
5. April 21, 2014, before the breakfast meal, no accucheck was obtained; and on
6. April 23, 2014, at "6A (6:00 a.m.)" no accucheck was obtained.

Interview with Licensed Practical Nurse (LPN) #1 assigned to resident #14, on April 21, 2014, at

{F 333}

will be conducted by the pharmacist at Office #1.

- Packaging of product will be performed by the pharmacy technician at Pharmacy Office #2.
- Final review of product and medication orders will be performed by the pharmacist at Pharmacy Office #2.

Due to Pharmacy Offices #1 and #2 being on the same computer system, this new pharmacy procedure will not impede nor slow down medication and MAR delivery to the facility. Pharmacy Office #2's pharmacy technicians and pharmacists were educated on 4/29/14 by the Vice President/Clinical Director of Pharmacy Services in person regarding the new procedure of Pharmacy Office #1 assuming the function of order entry and the procedure of orders being reviewed by four pharmacy staff, from both offices, to ensure accurate medication reconciliation from previous provider. 100% of pharmacy technicians and pharmacists were present for this in-service. No agency staff is used by Pharmacy #2. Pharmacy #1's pharmacy technicians and pharmacists were educated on 4/25/14 by the Vice President/Clinical Director of Pharmacy Services regarding the new procedure of Office #1 assuming all order entries and the procedure of orders being reviewed by four pharmacy staff from both offices. This in-service was repeated by the Pharmacy Operations Manager on 4/29/14; this ensured 100% pharmacy technicians and pharmacists were educated. Newly-hired pharmacy technicians and pharmacists will be educated during their orientation period by the Pharmacy Operations Manager regarding

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

(F 333) Continued From page 77

11:15 a.m., on the 100 hall revealed "...the night nurse (7:00 p.m. to 7:00 a.m. shift) obtains the blood sugar..." Further interview confirmed LPN #1 was not aware of the blood sugar result for 6:00 a.m. on April 21, 2014. Further interview confirmed the blood sugar level for April 21, 2014, at 6:00 a.m. was not documented on the Diabetic Medication Administration Record.

Interview with Nurse Consultant #1/Acting Director of Nursing, on April 21, 2014, at 11:38 a.m., in the Conference Room confirmed the blood sugar level and the insulin administration when the blood sugar was elevated was to be documented on the Diabetic Medication Administration Record. Further interview confirmed the April 2014, Diabetic Medication Administration Record lacked documentation of blood sugar levels on April 19, 2014, at 9:00 p.m. and on April 21, 2014, before the breakfast meal. Further interview confirmed the insulin should have been administered and the number of units administered was to be documented on April 18 and 19, 2014, at 5:00 p.m. and on April 20, 2014, at 11:00 a.m. due to the elevated accucheck results.

Interview with Medical Director #2, on April 21, 2014, at 11:52 a.m., in the Conference Room confirmed "...expect (resident #14) should have gotten sliding scale (insulin) per order (when blood sugar elevated)..."

Interview with LPN #5, on April 23, 2014, at 7:45 a.m., at the 200/300 nursing station, and Nurse Consultant #1/Acting Director of Nursing present, confirmed LPN #5 had been responsible for resident #14 during the 7:00 p.m.-7:00 a.m. shift and had not obtained the blood sugar level for the

(F 333) new order entry system, new facility-cover sheets for faxing admission/re-admission orders to the pharmacy, and on-site daily audits of admission/re-admission orders for medication reconciliation accuracy. No agency staff is used by pharmacy #1. Beginning 4/28/14, the pharmacy will provide the facility with a cover sheet for admission/ re-admission orders that will consist of a bar code that will move these orders to an "as soon as possible" status for the pharmacy . This cover sheet will also consist of nurse contact number for any clarification Issues, and number of pages faxed to the pharmacy. Vice President/Clinical Director of Pharmacy Services conducted mandatory in-services for facility licensed staff on 4/28/14 and 4/29/14 regarding utilization of the new Fax Cover Sheets for Admissions Office, new Fax Cover Sheets for nurses to utilize for admissions/ re-admissions, and tips for writing and sending medication orders. The Nursing Supervisor receives the carbon copies of all orders written in the facility. Transcription of medication orders onto the MARs will be checked by Nursing Supervisor daily to ensure accurate medication reconciliation occurred. Charge Nurse will reconcile all orders written on the weekend.

Monitoring

The results of the daily accu-check/sliding scale insulin audits will be presented by the ADON to the monthly Performance Improvement Committee for review and recommendations until desired threshold of 100% is met for three consecutive months; then quarterly. The results of the daily audits of the new

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

{F 333} Continued From page 78
morning of April 23, 2014.

Interview with LPN #4, and observation on April 23, 2014, at 7:50 a.m., and Nurse Consultant #1/Acting Director of Nursing present, outside the room of resident #14, confirmed LPN #4 was responsible for resident #14 for the 7:00 a.m.-7:00 p.m. shift and had not obtained the blood sugar level for the morning of April 23, 2014. When LPN #4 was asked if the blood sugar had been obtained this nurse stated "No, the night shift (7:00 p.m.-7:00 a.m.) does it."

Interview with LPN #8 and Nurse Consultant #2, on April 24, 2014, at 10:15 a.m., at the 100/200 nursing station, confirmed the resident had been admitted on March 31, 2014, at 2:50 p.m. and had been discharged before breakfast on April 1, 2014. Further interview confirmed the accucheck for March 31, 2014, at 5:00 p.m. was not obtained.

The facility's failure to monitor the blood sugar level and the failure to administer the prescribed insulin when the blood sugar was elevated resulted in significant medication errors and placed resident #14 in immediate Jeopardy.

Validation of the Credible Allegation of Compliance was accomplished on-site on May 13, 2014, and May 14, 2014, through medical record reviews, review of facility documents, and interviews with Nursing and Administrative Staff.

Medical record review of the closed chart of resident #3 revealed the resident's Physician Orders and Medication Administration Records were reconciled accurately on March 31, 2014. Resident #3 was discharged from the facility on

{F 333} Medication Reconciliation Procedure of verifying all admission/re-admission orders by two nurses and faxing only the orders provided by EMS/accompanied by the resident to the pharmacy, results of the daily on site pharmacist review of admission/re-admission orders will be presented by the DON to the monthly Performance Improvement Committee for review and recommendations until desired threshold of 100% has been met for three consecutive months; then quarterly. A Performance Improvement Committee meeting consisting of the Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Pharmacy Consultant, Quality Assurance Nurse, and MDS Nurses was conducted on 5/22/14 and results of the above audits were found to be in continued compliance. The daily accu-checks/sliding scale insulin administration audits and the daily medication reconciliation audits will continue to be completed daily for three months as a recommendation from this Performance Improvement Committee and will continue to be reviewed monthly by the Performance Improvement Committee for recommendations regarding monitoring frequency, adjustments to monitoring, and/or system changes. The Administrator and DON will follow-up on recommendations from the Performance Improvement Committee to assure continued compliance. The Performance Improvement Committee consists of the Administrator, Medical Director, Business Office Manager, Director of Nursing, Assistant Director of Nursing, Human Resources Clerk, Clinical Records Clerk, Marketing/Admissions Director, Director of Housekeeping/Laundry, Maintenance Director, Director of Social

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 333}	Continued From page 79 April 1, 2014. Medical record review of resident #33 revealed the resident was readmitted to the facility on May 8, 2014. Continued review of the physician orders dated May 8, 2014, revealed the orders has been verified with the physician and signed by two licensed nurses. Medical record review of the Medication Administration Record from May 8-13, 2014, revealed the resident received medications as ordered. The facility provided evidence of audits of reconciliation of admission/re-admission orders, in-service training for all nursing staff related to physician notification of medication errors, admission/readmission physician order and medication reconciliation, medication omissions, blood glucose monitoring and shift to shift audits of accu-checks and sliding scale insulin, sliding scale insulin orders, and physician standing orders, and the pharmacy procedure for medication orders. The facility provided documentation of an emergency Performance Improvement Meeting held on April 28, 2014, to discuss the new admission/readmission medication reconciliation process, pharmacy process, and physician notification process and provided evidence of establishing a Performance Improvement Committee. Interviews with Nursing Staff on all shifts May 13-14, 2014, throughout the facility, revealed the nursing staff had been in-serviced on the protocol for new admission/readmission medication order reconciliation, pharmacy protocol, medication errors, and physician standing orders.	{F 333}	Services, Therapy Manager, Consultant Pharmacist, and Line-Staff Nurse.	5/22/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

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CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 EKON SPRINGS ROAD EAST SMYRNA, TN 37167

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(F 333)	Continued From page 80	(F 333)		

The facility will remain out of compliance at a Scope and Severity level "F" a deficient practice that constitutes no actual harm with potential for more than minimal harm, that is not immediate jeopardy until it provides an acceptable plan of correction and corrective actions are verified onsite..

C/O #33583

(F 425) SS=F 483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH

(F 425) F 425

The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.

This REQUIREMENT is not met as evidenced by:
Based on interview, review of the pharmacy

Christian Care Center of Rutherford County believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:

Corrective Actions for Targeted Residents

Resident #1 was a closed chart. Resident #3 was transferred to acute care on 3/29/14. Resident #3 returned to the facility on 3/31/14. Resident #3's medications were reconciled from the previous provider accurately on 3/31/14 by the DON. Resident #3 was discharged from the facility on 4/1/14. Resident #24 was discharged on 4/23/14. Medications for Residents #19, #10, #14, #26, #13, and #29 were reconciled by the DON on 4/25/14.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

(F 425) Continued From page 81

agreement with the facility, review of the agreement with the pharmacy consultant and the facility, and medical record review, the facility's contracted pharmacy failed to provide prescribed medication for five residents (#3, #19, #14, #1, #16); and failed to accurately transcribe medications on the admission/monthly Physician's Order (recapitulation) and/or the Medication Record (MAR) for six residents (#19, #14, #26 #13, #24, #29) of thirty-one residents reviewed.

The facility's contracted pharmacy and the facility's systemic failure to compare/reconcile medications with physician orders and provide medications as ordered by the physician, and the failure to accurately transcribe medications on the admission/monthly Physician Orders and/or MAR placed residents all residents in the potential for Immediate Jeopardy (a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death to a resident).

The Administrator, Regional Administrator Consultant, Assistant Director of Nursing, Nurse Consultant #1/Acting Director of Nursing, Nurse Consultant #2, Nurse Consultant #3, Vice-President of Client Operations, and Medical Director #1 were informed of the Immediate Jeopardy on April 24, 2014, at 10:55 a.m., in the Conference Room.

The Immediate Jeopardy was effective March 14, 2014, and was ongoing.

An extended survey was conducted on April 24, 2014.

(F 425) Identification of Other Residents with Potential to be Affected

Current residents have the potential to be affected by this practice. A 100% audit of active resident's admission/re-admission orders from the facility-pharmacy matching the discharge orders from the previous provider, ensuring all pages were faxed to the pharmacy and reconciled correctly onto the MARs, was conducted by the DON and Nurse Consultant beginning on 4/18/14; completed on 4/22/14. The results of these admission/re-admission order audits and the action taken by the DON and Nurse Consultant are as follows: Orders not transcribed correctly onto the MAR affected nine residents. These residents' medications were reconciled correctly onto the MAR by the Nurse Consultant on 4/22/14. Omission of medication administration doses affected two residents. MD and family were notified of errors on 4/22/14 by the Nurse Consultant. Nursing education for licensed staff by DON occurred regarding these errors on 4/22/14. On 4/25/14, the DON re-wrote clarification orders by matching current medication orders with current MARs to ensure physician's orders were followed and medication reconciliation was correct for all resident-charts cited during this survey. Remaining residents' medications will be reconciled by Nursing Staff during the Monthly MAR change-over procedure for 5/1/14. This MAR change-over was double-checked by the Nurse Consultant on 4/29 and 4/30/14 to ensure accurate medication reconciliation onto the new MAR.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(F 425)	Continued From page 82	(F 425)	Systematic Changes Standing Orders were revised and signed by the Medical Director on 4/28/14. Facility protocol for sliding scale insulin administration was discontinued by the Medical Director on 4/28/14. Per the Medical Director's approval, sliding scale insulin administration will follow the physician's discharge orders from the hospital/previous provider. Pharmacy was notified of this revision for Standing Orders on 4/29/14 by the DON. Pharmacy staff was in-serviced regarding standing orders by the Regional Director of Pharmacy on 4/28/14 and 4/29/14. These Standing Orders were placed in the residents' charts and in the front of the MARs by the DON on 4/29/14, who instructed each nurse when and how to use these orders and where they could be located; completed 5/1/14. Beginning 4/22/14, the new procedure was initiated of the Consultant Pharmacist conducting a daily audit, on-site at the facility, of hospital/previous provider discharge orders to ensure accurate medication reconciliation from the previous provider was received by the pharmacy, and that all pages of admission/re-admission orders were received by the pharmacy. On-call pharmacist will conduct this audit, on-site at the facility, of medication reconciliation of new admissions/re-admissions on the weekends. This daily audit of admission/re-admission orders by the pharmacist will be on-going until desired threshold of 100% is met for three consecutive months; then quarterly. On 4/18/14, the DON initiated in-services for licensed staff regarding the new Medication Reconciliation Procedure of admission/re-admission orders being verified	

Substandard Quality of Care was cited at F224-K, F309-K, and F333-L.

The facility provided an acceptable Allegation of Compliance on May 8, 2014, and a revisit on May 13, 2014, and May 14, 2014, revealed the corrective actions implemented on May 2, 2014, removed the immediacy of the jeopardy.

Noncompliance for F-425 continues at a "F" level citation for the facility's monitoring the effectiveness of corrective actions in order to ensure sustained compliance and evaluation of the processes by the Quality Assurance Committee.

The findings included:

Interview with the Director of Nursing and Nurse Consultant #1, on April 15, 2014, at 2:45 p.m., in the conference room, revealed the the hospital discharge medication reports were delivered to the facility. Further interview revealed the facility faxed the hospital discharge medication report to the pharmacy. Further interview revealed the pharmacy generated the facility physician medication orders and the MAR. Further interview revealed the pharmacy delivered the facility admission physician orders for the physician's signature and the MAR to the facility along with the medications prescribed. Further interview confirmed the facility physician orders were utilized as the primary reference for the physician orders by the facility staff.

Review of the agreement between the pharmacy and the facility, dated June 2011, revealed the "Duties and Obligations of the Pharmacy"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

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(F 425) Continued From page 83

included; "...support and delivery of medications to the facility (twenty-four hours per day, seven days per week)...Medication Administration records...physician order forms, flow sheets..."

Review of the agreement with the pharmacy consultant and the facility dated June 2011, revealed "Responsibilities and Functions"...the "Consultant agrees to:...Complete monthly patient medication reviews...Participate in Quality Assurance Committee Meetings and provide administrative/professional guidance to administrative staff for the development and implementation..."

Medical record review of resident #3 revealed the hospital discharge medication report including the six medication of Coumadin (blood thinner), Lipitor (statin drug for cholesterol management), Coreg medication to regulate heart rate), Digoxin medication to slow heart rate and control rhythm), Cardizem medication to control heart rate and blood pressure), and Lisinopril (medication to control high blood pressure). Medical record review revealed the pharmacy failed to transcribe the six medications onto the facility admission physician orders and the MAR. The failure of the facility to provide the six medications from March 14-29, 2014, resulted in the resident's hospitalization with exacerbation of Atrial Fibrillation and a subtherapeutic Digoxin level placed resident #3 in immediate Jeopardy.

Medical record review of resident #19, receiving dialysis treatment three days per week, revealed the March 2014, hospital discharge medications did not include PhosLo (Calcium Acetate-used to bind the phosphorus in the body to decrease the level of the phosphorus in the blood) and Crestor

(F 425) and reconciled onto the MAR by two nurses initialing both forms, and the Admitting Nurse placing a telephone call to the newly-admitted resident's attending physician to review, adjust, and accept admission orders. Any clarification orders given by the admitting physician will be taken by the Admitting Nurse as a telephone order and faxed to the pharmacy with the admission/re-admission orders brought by EMS/accompanied by the resident. These in-services for medication reconciliation are ongoing by the DON until all nurses are educated, with completion date of 4/29/14. Newly-hired and agency nurses will be educated by the DON, prior to reporting to the floor for the first time, regarding the new Medication Reconciliation Procedure of having two nurses verify admission/re-admission orders, verifying admission orders with the attending physician, and faxing only the orders brought by EMS/accompanied by the resident to the pharmacy. Newly-hired and agency nurses will also be educated by the DON to perform accu-checks and administer sliding scale insulin as ordered by the physician by performing every shift audits of the Diabetic Flow Record for accuracy with the oncoming nurse. On 4/1/14, Pharmacy Personnel were in-serviced by Regional Director regarding verifying all numbered pages of admission/re-admission orders and calling the facility to verify number of pages faxed. Beginning 4/25/14, the new procedure was initiated of the pharmacy staff at Pharmacy Office #1, home office, assuming the function of order entry to ensure initial medication reconciliation accuracy. The pharmacist at Pharmacy Office #2 will be the second check once the order is filled.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

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(F 425) Continued From page 84

(an antistatin medication to lower cholesterol) at 20 milligrams (mg). Further review of the hospital discharge medications revealed Mirtazapine (antidepressant medication) and Protonix (medication to control stomach acid) were included. Medical record review of the March 2014, facility admission physician medication order revealed the pharmacy incorrectly included the PhosLo and Crestor 20 mg (although they were not ordered) onto the forms. Further review of the facility admission physician medication order revealed the pharmacy failed to transcribe the Mirtazapine and Protonix (although they were ordered) onto the forms. Medical record review of the facility March 2014 MAR revealed the administration of PhosLo and Crestor. Medical record review of the April 2014 Physician Orders and the April 2014 MAR revealed the pharmacy incorrectly transcribed the Crestor as 10 mg (although 20 mg was ordered). The failure of the pharmacy to accurately transcribe and provide medication placed resident #19 in immediate Jeopardy.

Medical record review for resident #14 revealed the hospital discharge medications included Gabapentin 800 milligrams (mg). Medical record review of the facility readmission medication orders and the MAR revealed the Gabapentin (medication to treat nerve pain) 800 mg was not included and the pharmacy failed to provide the medication.

Medical record review for resident #1 revealed the hospital discharge medications included Metoprolol (medication to control blood pressure). Medical record review of the facility admission physician orders and the MAR revealed the pharmacy failed to transcribe Metoprolol onto the

(F 426) Beginning 4/25/14 all new orders, including admission/re-admission orders, will be reviewed by four pharmacy staff by the following procedure:

- Order entry will be performed by pharmacy technician at Pharmacy Office #1.
- Order entry/clinical review for accuracy will be conducted by the pharmacist at Office #1.
- Packaging of product will be performed by the pharmacy technician at Pharmacy Office #2.
- Final review of product and medication orders will be performed by the pharmacist at Pharmacy Office #2.

Due to Pharmacy Offices #1 and #2 being on the same computer system, this new pharmacy procedure will not impede nor slow down medication and MAR delivery to the facility. Pharmacy Office #2's pharmacy technicians and pharmacists were educated on 4/29/14 by the Vice President/Clinical Director of Pharmacy Services in person regarding the new procedure of Pharmacy Office #1 assuming the function of order entry and the procedure of orders being reviewed by four pharmacy staff, from both offices, to ensure accurate medication reconciliation from previous provider. 100% of pharmacy technicians and pharmacists were present for this in-service. No agency staff is used by Pharmacy #2. Pharmacy #1's pharmacy technicians and pharmacists were educated on 4/25/14 by the Vice President/Clinical Director of Pharmacy Services regarding the new procedure of office #1 assuming all order entries and the procedure of orders being

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

{F 425} Continued From page 85
form and failed to provide the medication.

Medical record review for resident #10 revealed the hospital discharge medications included lubricating top jelly bacteriostatic. Medical record review of the facility admission physician orders and the MAR revealed the pharmacy failed to transcribe the lubricating top jelly bacteriostatic onto the forms. Interview with Pharmacist #1, on April 22, 2014, at 1:25 p.m., in the Conference Room, confirmed the lubricating jelly was "...a blatant omission by pharmacy..." and failed to provide the medication.

Medical record review for resident #26 revealed the hospital discharge medications included Tylenol (medication for control of pain/fever) with no specified frequency of administration. Medical record review of the facility admission physician orders and the MAR revealed the pharmacy failed to transcribe Tylenol onto the forms. Interview with Pharmacist #1 confirmed the attempt and failure to obtain a clarification order prior to providing the facility with the physician orders and the MAR.

Medical record review of resident #13 revealed the February 2014 hospital discharge medications included a cranberry supplement. Medical record review of the facility admission physician order and the MAR revealed the pharmacy failed to transcribe the cranberry supplement onto the forms. Medical record review of the March 2014 hospital discharge medications included Aspirin and a cranberry supplement. Medical record review of the facility admission physician order and the MAR revealed the pharmacy failed to transcribe the Aspirin onto the forms.

{F 425} reviewed by four pharmacy staff from both offices. This in-service was repeated by the Pharmacy Operations Manager on 4/29/14; this ensured 100% pharmacy technicians and pharmacists were educated. Newly-hired pharmacy technicians and pharmacists from Pharmacy Offices #1 and #2 will be educated during their orientation period by the Pharmacy Operations Manager regarding new order entry system, new facility-cover sheets for faxing admission/re-admission orders to the pharmacy, and on-site daily audits of admission/re-admission orders for medication reconciliation accuracy. No agency staff is used by Pharmacy #1. Vice President/Clinical Director of Pharmacy Services conducted mandatory in-services for facility licensed staff on 4/28/14 and 4/29/14 regarding utilization of the new Fax Cover Sheets for Admissions Office, new Fax Cover Sheets for nurses to utilize for admissions/re-admissions, and tips for writing and sending medication orders. 100% of facility licensed staff attended one of these in-services. Newly-hired and agency licensed staff will be in-serviced by the DON, prior to reporting to the floor for the first time, regarding the new pharmacy cover sheet to be utilized with admission/re-admission orders to place those orders in a "priority" status for the pharmacy. Beginning 4/28/14, the pharmacy will provide the facility with a cover sheet for admission/re-admission orders that will consist of a bar code that will move these orders to an "as soon as possible" status for the pharmacy. This cover sheet will also consist of nurse contact number for any clarification issues, and number of pages faxed to the pharmacy. Vice President/

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445592	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 86	F 425	Clinical Director of Pharmacy Services conducted mandatory in-services for facility licensed staff on 4/28/14 and 4/29/14 regarding utilization of the new Fax Cover Sheets for Admissions Office, new Fax Cover Sheets for nurses to utilize for admissions/re-admissions, and tips for writing and sending medication orders. The Nursing Supervisor receives the carbon copies of all orders written in the facility. Transcription of medication orders onto the MARs will be checked by Nursing Supervisor daily to ensure accurate medication reconciliation. Charge Nurse will reconcile all orders written on the weekend.	

Medical record review for resident #24 revealed the hospital discharge medications included Melatonin (herbal medication prescribed for sleep) at 4 mg, Latuda (an atypical antipsychotic medication prescribed for anxiety) at 20 mg twice daily and Latuda 10 mg as needed. Medical record review of the facility admission physician order and the MAR revealed the pharmacy incorrectly transcribed the Melatonin as 5 mg. Medical record review of the facility admission physician order and the MAR revealed the pharmacy failed to transcribe both orders for Latuda.

Medical record review for resident #29 revealed the hospital discharge medications included Gabapentin (medication used to treat pain and anxiety) and Metoclopramide (medication to aid in stomach emptying). Medical record review of the facility admission physician order and the MAR revealed the pharmacy incorrectly transcribed the Gabapentin onto the forms.

Interview with Pharmacist #1 on April 22, 2014, at 1:25 a.m., in the conference room, revealed the facility identified a breakdown in communication between the pharmacy and the facility in early April. Further interview confirmed prior to the last Performance Improvement meeting held April 10, 2014, the pharmacy did not compare/reconcile hospital discharge medication to the facility admission physician orders to ensure accuracy. Further interview revealed "...assumed orders verified prior to contact with (pharmacy) or that the nursing facility made a clarification order prior to contacting the (Pharmacy)..." Further interview confirmed the pharmacy made "...blatant omission (to provide medications prescribed)..."

Monitoring

The results of the daily audits of the new Medication Reconciliation Procedure of verifying all admission/re-admission orders by two nurses and faxing the orders provided by EMS/accompanied by the resident to the pharmacy, results of the daily on site pharmacist review of admission/re-admission orders will be presented by the DON to the monthly Performance Improvement Committee for review and recommendations until desired threshold of 100% has been met for three consecutive months; then quarterly. A Performance Improvement Committee meeting consisting of the Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Pharmacy Consultant, Quality Assurance Nurse and MDS Nurses was conducted on 5/22/14 and results of the above audit were found to be in continued compliance. The daily medication reconciliation audits will continue to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	440502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	702 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

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F 425	Continued From page 87 Refer to F157-J, F224-K, F281-L, F309-J, F333-L. Validation of the Credible Allegation of Compliance was accomplished on-site on May 13, 2014, and May 14, 2014, through medical record reviews, review of facility documents, and interviews with Nursing and Administrative Staff. The facility provided evidence of audits of reconciliation of admission/re-admission orders, in-service training for all nursing staff related to physician notification of medication errors, admission/readmission physician order and medication reconciliation, medication omissions, blood glucose monitoring and shift to shift audits of accu-checks and sliding scale insulin, sliding scale insulin orders, and physician standing orders, and the pharmacy procedure for medication orders. The facility provided documentation of an emergency Performance Improvement Meeting held on April 28, 2014, to discuss the new admission/readmission medication reconciliation process, pharmacy process, and physician notification process. Interviews with Nursing Staff on all shifts May 13-14, 2014, throughout the facility, revealed the nursing staff had been in-serviced on the protocol for new admission/readmission medication order reconciliation, pharmacy protocol, medication errors, and physician standing orders. Interview on May 13, 2014, at 9:50 a.m., with the Pharmacist, in the conference room, revealed all medication orders were entered by a pharmacy	F 425	completed daily for three months as a recommendation from this Performance Improvement Committee and will continue to be reviewed monthly by the Performance Improvement Committee for recommendations regarding monitoring frequency, adjustments to monitoring, and/or system changes. The Administrator and DON will follow up on recommendations from the Performance Improvement Committee to assure continued compliance. The Performance Improvement Committee consists of Administrator, Medical Director, Business Office Manager, Director of Nursing, Assistant Director of Nursing, Human Resources Clerk, Clinical Records Clerk, Marketing/Admissions Director, Director of Housekeeping/Laundry, Maintenance Director, Director of Social Services, Therapy Manager, Consultant Pharmacist, and Line-Staff Nurse.	5/22/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	B. WING	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 425}	Continued From page 88 technician, at pharmacy office #1, then the medication orders were checked by the Pharmacist at pharmacy office #1, and the Pharmacist at pharmacy office #2 would provide a second check to ensure the physician orders were followed and medications delivered to the facility as ordered. Continued interview revealed a new fax sheet with a barcode had been implemented to ensure new admission/re-admission orders from the facility were triaged with a high importance. Continued interview revealed all new orders were checked the next day on-site by pharmacy services. Continued interview confirmed the four pharmacy staff members had received in-service education on the new procedures. The facility will remain out of compliance at a Scope and Severity level "F" a deficient practice that constitutes no actual harm with potential for more than minimal harm, that is not Immediate Jeopardy until it provides an acceptable plan of correction and corrective actions are verified onsite.. C/O #33583	{F 425}		
{F 490}	483.75 EFFECTIVE SS=F ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:	{F 490}	F 490 Christian Care Center of Rutherford County believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445302	A. BUILDING _____ B. WING _____	C 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

(F 490) Continued From page 89

Based on medical record review, review of facility Plan of Correction, facility policy review, and interview, the facility failed to be administered in a manner to ensure physician's orders were followed for eleven residents (#1, #3, #10, #13, #14, #19, #24, #26, #28, #29, #30), failed to administer medications as ordered resulting in neglect of one resident (#3), failed to ensure quality of care for eight residents (#1, #3, #10, #13, #14, #19, #24, #29), failed to ensure the facility was free from significant medication errors for one resident (#3), and failed to ensure implemented interventions addressed during Performance Improvement were effective. The facility personnel failed to identify significant medication errors when completing medication audit. The facility's failure to ensure physician's orders were followed, failure to administer medications as ordered, failure to ensure the facility was free from significant medication errors and failure to ensure an effective Performance Improvement plan was implemented, resulted in Immediate Jeopardy for residents #3, #19, and #14 (a situation in the provider's noncompliance with one or more requirements of participation has caused, or was likely to cause, serious injury, harm impairment or death), and potentially for all residents in the facility.

The Administrator, Regional Administrator Consultant, Assistant Director of Nursing, Nurse Consultant #1/Acting Director of Nursing, Nurse Consultant #2, Nurse Consultant #3, Vice-President of Client Operations, and Medical Director #1 were informed of the Immediate Jeopardy on April 24, 2014, at 10:55 a.m., in the Conference Room.

The Immediate Jeopardy was effective March 14,

(F 490) Corrective Actions for Targeted Residents

Physician's Orders are now being followed for Residents #10, #13, #14, #19, #26, #28, #29 and #30. Resident #1 was a closed chart. Resident #24 was discharged on 4/23/14. Resident #3 was transferred to acute care on 3/29/14. Resident #3 returned to the facility on 3/31/14. Resident #3's medications were reconciled from the previous provider accurately on 3/31/14 by the DON. Resident #3 was discharged from the facility on 4/1/14. Administrator was made aware of medication reconciliation issues on 4/2/14. The updated POC provided to the surveyors by the DON on 4/21/14 was not acceptable.

Identification of Other Residents with Potential to be Affected

Current residents have the potential to be affected by this practice. The personnel change for the facility Administrator was conducted on 4/28/14. The personnel change for the facility Nurse Consultant #1/Acting DON was conducted on 4/18/14. On 4/28/14, the Interim Administrator was educated by the Nurse Consultant #1/Acting DON with information regarding new Medication Reconciliation Procedure, new Performance Improvement audits and procedures for accu-checks and sliding scale insulin, and ongoing education for nursing staff as well as any other follow-up to recent survey.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

{F 490} Continued From page 90
2014, and was ongoing.

An extended survey was conducted on April 24, 2014.

Substandard Quality of Care was cited at F224-K, F309-K, and F333-L.

The facility provided an acceptable Allegation of Compliance on May 8, 2014, and a revisit on May 13, 2014, and May 14, 2014, revealed the corrective actions implemented on May 2, 2014, removed the immediacy of the Jeopardy.

Noncompliance for F-490 continues at a "F" level citation for the facility's monitoring the effectiveness of corrective actions in order to ensure sustained compliance and evaluation of the processes by the Quality Assurance Committee.

The findings included:

Review of facility Plan of Correction (facility's own, internal corrective action plan), completed by the Director of Nursing (DON) on April 2, 2014, in response to the discovery of the significant medication errors of resident #3, revealed the facility became aware of medications which were being omitted from the hospital discharge records when reconciled with the facility's admission medication orders and Medication Records (MARs) sent from the pharmacy. Continued review revealed a Plan of Correction was instituted by the DON which stated the facility would complete a 100 % (percent) audit of all active residents by conducting a reconciliation with the MARs and the Physician Orders. Continued review revealed the Plan of Correction

{F 490}

Systematic Changes

Administrative staff will be made aware by the DON/ADON on a daily basis during Stand-Up Meeting of Administrative staff every morning—and throughout the day–of results of any noncompliance issues found on daily audits of New Medication Reconciliation Procedure, daily accu-check performance/ sliding scale insulin administration, significant medication errors, and failure to follow physician's orders. Stand-Up Meetings consist of Administrator, Business Office Manager, Director of Nursing, Assistant Director of Nursing, Human Resources Clerk, Clinical Records Clerk, Marketing/Admissions Director, MDS Coordinator, Assessment Nurse, Director of Activities, Director of Dietary, Director of Housekeeping/Laundry, Maintenance Director, Director of Social Services, and Therapy Manager. Non-compliance issues will be addressed by the Administrator and Department Director involved. Continued Performance Improvement audits will be presented to the Administrator by the DON/ADON for review/recommendations, for change/ improvements, and follow-up action for noncompliance.

Monitoring

A Performance Improvement Committee meeting will be held monthly for discussion and communication by the DON/ADON of issues found from results of the New Medication Reconciliation Audits, accu-check

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	446502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

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F 490	Continued From page 91	F 490		

was to provide education of all Licensed Nursing Staff of the new system to be instituted requiring two nurses to double check the hospital discharge orders with the Physician's Orders and the MARs. Further review revealed the Plan of Correction was for each admission record to be reviewed in morning Stand-up meeting on the "following business day" after a resident's admission to the facility. Continued review revealed each physician order, after a resident's admission to the facility, was to be verified by nursing administration "...the following business day..." Continued review of The Plan of Correction revealed the plan was ongoing with each new admission and physician order.

Interview with the DON and Nurse Consultant #1 on April 17, 2014, at 2:55 p.m., in the Conference Room, confirmed the audit was completed per the Plan of Correction dated April 2, 2014, of all residents in the facility. Continued interview confirmed Nurse Consultant #1 emailed the results of the audit to the DON on April 4, 2014. Further interview confirmed both the DON and Nurse Consultant #1 were aware of the results of the audit which documented resident #19 was receiving medications which had not been ordered on admission, and were aware resident #19 was not receiving other medications which had been ordered. Continued interview confirmed both the DON and Nurse Consultant #1 failed to follow-up on the audit as of the time of the interview on April 17, 2014.

Interview with the Administrator on April 21, 2014, at 9:40 a.m., in the Conference Room, confirmed the Administrator was also notified by email on April 4, 2014, of the results of the chart audits. Continued interview with the Administrator

performance/sliding scale administration audits, failure to follow physician's orders, failure to be free of significant medication errors and other resident issues that have arisen to ensure there is an effective Performance Improvement Plan in place. A Performance Improvement Committee meeting consisting of the Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Pharmacy Consultant, Quality Assurance Nurse, and MDS Nurses was conducted on 5/22/14 and results of the above audits were found to be in continued compliance. The daily accu-checks/sliding scale insulin administration audits and the daily medication reconciliation audits will continue to be completed daily for three months as a recommendation from this Performance Improvement Committee and will continue to be reviewed monthly by the Performance Improvement Committee for recommendations regarding monitoring frequency, adjustments to monitoring, and/or system changes. The Administrator and DON will follow up on recommendations from the Performance Improvement Committee to assure continued compliance. The Performance Improvement Committee consists of the Administrator, Medical Director, Business Office Manager, Director of Nursing, Assistant Director of Nursing, Human Resources Clerk, Clinical Records Clerk, Marketing/Admissions Director, Director of Housekeeping/Laundry, Maintenance Director, Director of Social Services, Therapy Manager, Consultant Pharmacist, and Line-Staff Nurse. The facility's governing body will increase the frequency of Nurse Consultant visits to twice a month for three months. The facility's governing body will

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	440502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 490}	Continued From page 92 confirmed the Administrator also failed to follow-up on the results of the audit and was aware the medication errors had been identified. Further interview confirmed no action had been taken by Nursing Administration Staff or the Administrator to address the audit concerns. Further interview confirmed the Administrator had participated in the last Performance Improvement meeting on April 10, 2014, and "...talked about reconciliations..." Further interview confirmed facility management had identified the issues with medication reconciliation processes and had developed Plan of Correction on April 2, 2014. Continued interview confirmed the Administrator had "...discussions..." with the pharmacy related to the medication errors which had occurred. Further interview confirmed no new plan had been put in place since the original Plan of Correction presented by the DON on April 2, 2014. Refer to F157-J, F224-K, F281-L, F309-K, F333-L, F425-L Validation of the Credible Allegation of Compliance was accomplished on-site on May 13, 2014, and May 14, 2014, through medical record reviews, review of facility documents, and interviews with Nursing and Administrative Staff. The facility provided evidence of audits of reconciliation of admission/re-admission orders, in-service training for all nursing staff related to physician notification of medication errors, admission/readmission physician order and medication reconciliation, medication omissions, blood glucose monitoring and shift to shift audits of accu-checks and sliding scale insulin, sliding scale insulin orders, and physician standing	{F 490}	also have a Nurse Consultant present for the Performance Improvement Committee meetings for three months to ensure continued compliance and system monitoring. The facility's governing body is a Management Consulting entity.	5/22/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

{F 490} Continued From page 93

orders, and the pharmacy procedure for medication orders.

The facility provided documentation of an emergency Performance Improvement Meeting held on April 28, 2014, to discuss the new admission/readmission medication reconciliation process, pharmacy process, and physician notification process.

Interviews with Nursing Staff on all shifts May 13-14, 2014, throughout the facility, revealed the nursing staff had been in-serviced on the protocol for new admission/readmission medication order reconciliation, pharmacy protocol, medication errors, and physician standing orders.

Interview with the Administrator on May 14, 2014, at 8:40 a.m., in the conference room, revealed the facility leadership group, the Director of Nursing, and the Medical Director, reviewed the findings of the survey and implemented follow-up audit measures to ensure compliance with corrective actions with initiating a Performance Improvement Committee.

The facility will remain out of compliance at a Scope and Severity level "F" a deficient practice that constitutes no actual harm with potential for more than minimal harm, that is not immediate Jeopardy until it provides an acceptable plan of correction and corrective actions are verified onsite.

C/O #33583

{F 501} 483.75(l) RESPONSIBILITIES OF MEDICAL

{F 490}

F 501

Christian Care Center of Rutherford County believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445597	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 501	Continued From page 94 SS=F DIRECTOR The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies, and the coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on review of Co-Medical Director Agreements, and interview, the facility failed to ensure one medical director was designated to be responsible and accountable for oversight of resident care policies, procedures and services. The failure of the facility to appoint one medical director resulted in inaccurate medication administration procedures that placed three residents (#3, #14, #19) of thirty-one residents reviewed in Immediate Jeopardy (a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death), and placed any resident who receives medications at risk. The Administrator, Regional Administrator Consultant, Assistant Director of Nursing, Nurse Consultant #1/Acting Director of Nursing, Nurse Consultant #2, Nurse Consultant #3, Vice-President of Client Operations, and Medical Director #1 were informed of the Immediate Jeopardy on April 24, 2014, at 10:55 a.m., in the Conference Room. The Immediate Jeopardy was effective March 14, 2014, and was ongoing.	F 501	Corrective Actions for Targeted Residents The facility has only one Medical Director who has served in this capacity since June 16, 2010. The Medical Director is responsible for reviewing resident care policies, procedures, and services as were emphasized during a Performance Improvement meeting conducted on April 28, 2014. At the same meeting the Medical Director participated in the formulation of corrective procedures concerning physician's orders and medical administration errors. The Medical Director will continue to attend regular Performance Improvement meetings and to review and approve and advise facility in the development and implementation the resident care policies, procedures, and services. Resident #3 was transferred to acute care on 3/29/14. Resident #3 returned to the facility on 3/31/14. Resident #3's medications were reconciled from the previous provider accurately on 3/31/14 by the DON. Resident #3 was discharged from the facility on 4/1/14. Resident #19's medication orders were reconciled on 4/17/14 by the DON. MD and Resident #19's family were notified of medication errors on 4/17/14. Resident #14's accu-check time was changed from 6am to 7am on 4/21/14 by the MD to be closer to mealtime. Resident #14's family was notified of medication errors on 4/21/14 by the DON. Identification of Other Residents with Potential to be Affected Current residents have a potential to be affected by this practice. Any issues of noncompliance of medication reconciliation,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445592	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

{F 501} Continued From page 95

An extended survey was conducted on April 24, 2014.

Substandard Quality of Care was cited at F224-K, F309-K, and F333-L.

The facility provided an acceptable Allegation of Compliance on May 8, 2014, and a revisit on May 13, 2014, and May 14, 2014, revealed the corrective actions implemented on May 2, 2014, removed the immediacy of the Jeopardy.

Noncompliance for F-501 continues at a "F" level citation for the facility's monitoring the effectiveness of corrective actions in order to ensure sustained compliance and evaluation of the processes by the Quality Assurance Committee.

The findings included:

Review of the facility's Medical Director Agreement revealed the facility had three co-medical directors, not one.

Review of Co-Medical Director Agreement signed and dated November 14, 2012, by Medical Director #2, revealed, "...Services of Physicians...As Co-Medical Director of facility, Physician shall perform those duties and responsibilities set forth in Addendum A, attached hereto...together with all other services to be provided by Physician hereunder, the 'Services'..." Further review revealed, "...Coordination of medical care in Facility...(iii) Facility's quality assurance program on a quarterly basis..." Continued review revealed, "...Addendum A...provides that medical directors

{F 501} accu-checks/sliding scale administration, drug irregularities, or inadequate medical care will be communicated to the Medical Director by the Director of Nursing on the day of discovery of issue to ensure appropriate steps are taken to remedy the problem.

Systematic Changes

The facility's Medical Director, Attending Physicians, and Interim Administrator were educated by the DON on 4/28/14 during a Focus Performance Improvement Committee Meeting regarding the results of issues found from the recent survey to include: Participation in the development of facility procedures and policies to address accurate medication administration and the Medical Director's role of implementation of resident-care policies and the coordination of medical care in the facility. This education included the Medical Director's role of evaluating and attempts to correct reports of inadequate medical care. The Medical Director was also reminded and reinstructed by the facility administrator and DON on 4/28/14 that he is required to continue attending the monthly Performance Improvement Committee Meetings. He was also reminded that he is expected to address issues, policies, medical care, suggestions for changes, as well as overall clinical care of the facility's residents in addition to ensuring the care and services are adequate and compliant at the facility. Standing Orders were revised and signed by the Medical Director on 4/28/14. Facility protocol for sliding scale insulin admini-

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	207 EKON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

{F 501} Continued From page 96

are responsible for...implementation of resident care policies and the coordination of medical care in the facility...'Resident care policies' include admissions, transfers and discharges...It also includes having a significant role in overseeing the overall clinical care of residents to ensure to the extent possible that care is adequate...When the medical director identifies or receives a report of possible inadequate medical care, including drug irregularities, (Medical Director), is responsible for evaluating the situation and taking appropriate steps to try to correct the problem...A medical director whose sole function is to approve resident care policies does not meet this requirement..."

Interview with Medical Director #2 on April 21, 2014, at 11:52 a.m., in the Conference Room, revealed "...was at the last Performance Improvement meeting (April 10, 2014)...don't remember specifics...talked about changing processes ..and issue with medications...I would expect something to happen...Not sure of specifics...Not aware of the what checks and balances in place...Not aware of what pharmacy has or had in place to correct issues..."

Review of Co-Medical Director Agreement signed and dated March 22, 2013, by Medical Director #3, revealed, "...Services of Physicians...As Co-Medical Director of facility, Physician shall perform those duties and responsibilities set forth in Addendum A, attached hereto...together with all other services to be provided by Physician hereunder, the 'Services'..." Further review revealed, "...Coordination of medical care in Facility...(iii) Facility's quality assurance program on a quarterly basis..." Continued review revealed, "...Addendum A...provides that medical

{F 501} stration was discontinued by the Medical Director on 4/28/14. Per the Medical Director's approval, sliding scale insulin administration will follow the physician's discharge orders from the hospital/previous provider. Pharmacy was notified of this revision for Standing Orders on 4/29/14. These Standing Orders were placed in the residents' charts and in the front of the MARs by the DON on 4/29/14, who instructed each nurse when and how to use these orders and where they could be located; completed on 5/1/14.

Monitoring

A Performance Improvement Committee meeting will be held monthly for discussion and communication of issues found from audit results of New Medication Reconciliation Audits, accu-check performance/sliding scale administration audits, failure to follow physician's orders, failure to be free of significant medication errors and other resident issues that have arisen. Information will be presented by the DON/ADON to ensure there is an effective Performance Improvement Plan in place. A Performance Improvement Committee meeting consisting of the Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Pharmacy Consultant, Quality Assurance Nurse, and MDS Nurses was conducted on 5/22/14 and results of the above audits were found to be in continued compliance. The daily accu-checks/sliding scale insulin administration audits and the daily medication reconciliation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 501}	Continued From page 97 directors are responsible for...implementation of resident care policies and the coordination of medical care in the facility..."Resident care policies' include admissions, transfers and discharges...It also includes having a significant role in overseeing the overall clinical care of residents to ensure to the extent possible that care is adequate...When the medical director identifies or receives a report of possible inadequate medical care, including drug irregularities, (Medical Director), is responsible for evaluating the situation and taking appropriate steps to try to correct the problem...A medical director whose sole function is to approve resident care policies does not meet this requirement..." Interview with Medical Director #3 on April 22, 2014, at 9:30 a.m., in the Conference Room, revealed "...was not at last Performance Improvement meeting (April 10, 2014)...was aware was working on issue of confusing hospital discharge orders due to multiple sets provided to the facility...The administrator has not as yet approached (Medical Director #3) to address the issue..." In summary, the facility's failure to designate only one physician as Medical Director resulted in no one (of the three co-medical directors) solely accountable to ensure implementation of resident care policies and the coordination of medical care in the facility, including accurate medication administration. Refer to F157-J, F224-K, F281-L, F309-K, F333-L, F425-L, F490-L Validation of the Credible Allegation of	{F 501}	audits will continue to be completed daily for three months as a recommendation from this Performance Improvement Committee and will continue to be reviewed monthly by the Performance Improvement Committee for recommendations regarding monitoring frequency, adjustments to monitoring, and/or system changes. The Administrator and DON will follow up on recommendations from the Performance Improvement Committee to assure continued compliance. The Medical Director will continue to attend regular Performance Improvement meetings and to review, approve and advise the facility in the development and implementation of the resident care policies, procedures, and services. The Performance Improvement Committee consists of the Administrator, Medical Director, Business Office Manager, Director of Nursing, Assistant Director of Nursing, Human Resources Clerk, Clinical Records Clerk, Marketing/Admissions Director, MDS Coordinator, Assessment Nurse, Director of Activities, Director of Dietary, Director of Housekeeping/Laundry, Maintenance Director, Director of Social Services, Therapy Manager, Consultant Pharmacist, and Line-Staff Nurse.	5/22/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

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{F 501}	Continued From page 98	{F 501}		

Compliance was accomplished on-site on May 13, 2014, and May 14, 2014, through review of facility documents, interviews with Nursing and Administrative Staff, and the Medical Director.

The facility provided evidence of audits of reconciliation of admission/re-admission orders, in-service training for all nursing staff related to physician notification of medication errors, admission/readmission physician order and medication reconciliation, medication omissions, blood glucose monitoring and shift to shift audits of accu-checks and sliding scale insulin, sliding scale insulin orders, and physician standing orders, and the pharmacy procedure for medication orders.

The facility provided documentation of an emergency Performance Improvement Meeting held on April 28, 2014, to discuss the new admission/readmission medication reconcilation process, pharmacy process, and physician notification process.

Interviews with Nursing Staff on all shifts May 13-14, 2014, throughout the facility, revealed the nursing staff had been in-serviced on the protocol for new admission/readmission medication order reconciliation, pharmacy protocol, medication errors, and physician standing orders.

Telephone interview on May 13, 2014, at 2:30 p.m., with the Medical Director revealed the facility had three physician's with admitting privitedges. Continued interview revealed the Medical Director assisted the facility with implementation and approval of protocols for resident care and to remove the immediate Jeopardy. Continued interview revealed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

{F 501} Continued From page 99

Medical Director and the other attending physicians communicated facility procedures during the Performance Improvement meetings, and discussed ways to address quality of care issues.

The facility will remain out of compliance at a Scope and Severity level "F" a deficient practice that constitutes no actual harm with potential for minimal harm, that is not Immediate Jeopardy until it provides an acceptable plan of correction and corrective actions are verified onsite.

C/0 #33583

{F 514} 483.75(l)(1) RES
SS=E RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on review of facility policy, review of the medical record, and interview, the facility failed to maintain complete and accurate medical records for six residents (#3, #10, #14, #18, #30, #27) of

{F 501)

F 514

(F 514)

Christian Care Center of Rutherford County believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:

Corrective Actions for Targeted Residents

Resident #3 was discharged from the facility on 4/1/14. Medication Administration Records were signed by licensed staff for Residents #10, #14, #18, and #30 on 5/1/14. Resident #14's accu-check time was changed from 6 am to 7am by the attending physician on 4/1/14 to be closer to mealtime. Resident #14's family was notified of medication errors on 4/21/14 by the DON. LPN #2 was counseled immediately on 4/22/14 by the DON regarding the correct method for documenting a "late entry" as was the case for Resident #27.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445592	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

(F 514) Continued From page 100

thirty-one resident records reviewed.

The findings included:

Review of facility policy, Charting and Documentation, last reviewed on September 2008, revealed "... Rules for Charting and Documentation...Be...accurate...Medication Administration...Document on the Medication Administration Record (MAR) as the medications are administered...Signature and title of person recording the data..."

Resident #3 was admitted to the facility on December 26, 2012, and readmitted to the facility on March 14, 2014, with diagnoses including Respiratory Failure, Chronic Atrial Fibrillation, Sinonal Node Dysfunction, Pneumonia, Chronic Obstructive Pulmonary Disease, Hypertension, and Cerebral Vascular Accident.

Medical record review of a nurse's note dated March 30, 2014, revealed, "...Late entry for 3/28/14. At approx. (approximately) 3 p.m. this nurse was called to resident room to assess resident. Resident in bed with eyes closed, shaking et (and) c/o (complained of) being cold. Resident alert et responsive. Vital signs T (temperature) 100.8 orally, P (pulse) 139 (normal range 60-100), R (respirations) 27, B/P (blood pressure) 156/92, O2 (oxygen) 78 % (percent) via (by) nc (nasal cannula) at 3 LPM (liters per minute). This nurse instructed patient to breathe in through nose et out through mouth. O2 increased to 83%. Nurse applied a non-rebreather oxygen mask et O2 increased to 86-92% fluctuating. Nurse notified MD (medical doctor) of pt (patient) status et N/O (new order) to send to ER (emergency room) for eval

(F 514) Identification of Other Residents with Potential to be Affected

Current residents have the potential to be affected by this practice. Facility Medication Administration Records were signed by licensed staff beginning with monthly MAR change-over on 5/1/14. All nurses are to sign with their first medication administration round for May, 2014, and every month thereafter. On 4/24/14, the new procedure began of each licensed nurse conducting an accu-check performance/sliding scale insulin administration audit every shift with the oncoming nurse for accuracy and completion of documentation onto the Diabetic Flow Record. Beginning 4/22/14 licensed staff was educated by the DON regarding proper documentation of a "late entry" by documenting the date and time a late entry is made, and the date and time that the "late entry" is for. This in-service was repeated by the DON on 4/28/14 to ensure all licensed staff was educated regarding appropriate documentation of "late entries." Beginning 4/24/14, licensed staff was in-serviced by the ADON regarding performing accu-checks and administering sliding scale insulin as ordered by the physician, with no omissions nor errors on the Diabetic Flow Record. This in-service was repeated on 4/28/14 and 4/29/14 by the Nurse Consultant to ensure all nurses were educated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 UNION SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 514}	Continued From page 101	{F 514}	Systematic Changes	

(evaluation) of tx (treatment)..." Continued review revealed, "...late entry for 3/29/14 5 pm. ER staff called at stated they needed a copy of resident's MAR. This nurse faxed MAR to number provided while on phone inquiring about resident's status. No new diagnosis from hospital at this time. This nurse was informed that diagnostic testing was still being performed..."

Medical record review of a nurse's note dated April 8, 2014, timed 2:49 p.m., and signed by the Director of Nursing (DON) revealed, "...Upon chart review it is noted on the late entry dated 3-30-14 @ (at) 730 a.m., (the note is for 3-26-14) the date for the late entry is incorrect and is actually for 3-29-14 which is when this resident was transferred to the ER for further eval and treatment..."

Resident #10 was admitted to the facility on March 28, 2014, and readmitted to the facility on April 9, 2014, with diagnoses including Diabetes Mellitus Type II, Arteriosclerotic Dementia, Major Depressive Disorder, Anxiety, and Affective Psychoses.

Medical record review of the March 2014 Medication Record (MAR documentation of medication administration) revealed the MAR was not signed by the nursing staff administering the medications.

Resident #14 was admitted to the facility March 31, 2014, discharged to the hospital on April 1, 2014, related to care for a cyst, and readmitted to the facility on April 11, 2014, with diagnoses including Diabetes Mellitus, Hypertension, Peripheral Neuropathy, Congestive Heart Failure,

Beginning 4/24/14, nurses will conduct an accu-check/sliding scale insulin administration audit every shift with the oncoming nurse. The DON/ADON will follow up on the results of these accu-check/sliding scale insulin audits on a daily basis. Nursing Supervisor will follow up on the results of these daily audits on the weekends. A monthly audit will be conducted by the DON to ensure that Medication Administration Records are signed by nurses who initial the front. Newly-hired nurses and agency nurses will be educated by the DON, prior to reporting to the floor for the first time, regarding the need for signing the back of MARs that have their initials on the front, performing accu-checks/sliding scale insulin administration per the physician's order, and the proper way of documenting a "late entry" in the medical record.

Monitoring

The results of the Medication Administration Record audit will be presented by the DON to the monthly Performance Improvement Committee for review and recommendations until desired threshold of 100% has been met for three consecutive months; then quarterly. The results of the daily audits of performing and documenting accu-checks/sliding scale insulin administration will be presented by the ADON to the monthly Performance Improvement Committee for review and recommendations until desired threshold has been met for three consecutive months; then quarterly. Random audits of 10% will be conducted by Medical Records throughout the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	233 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 102	F 514	month focusing on any "late entry" documentation for accuracy. Inappropriate "late entries" will be reported to the DON by the Medical Records Clerk the same day it is discovered. A Performance Improvement Committee, consisting of the Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Pharmacy Consultant, Quality Assurance Nurse, and MDS Nurses was held on 5/22/14 and results of the above audits were found to be in continued compliance. The daily accu-checks/sliding scale insulin administration audits and the daily medication reconciliation audits will continue to be completed daily for three months. Random audits focusing on "late entries" by the Medical Records Clerk will continue monthly as a recommendation from this Performance Improvement Committee and will continue to be reviewed monthly by the Performance Improvement Committee for recommendations regarding monitoring frequency, adjustments to monitoring, and/or system changes. The Administrator and DON will follow up on recommendations from the Performance Committee to assure continued compliance. The Performance Improvement Committee consists of the Administrator, Medical Director, Business Office Manager, Director of Nursing, Assistant Director of Nursing, Human Resources Clerk, Clinical Records Clerk, Marketing/Admissions Director, MDS Coordinator, Assessment Nurse, Director of Activities, Director of Dietary, Director of Housekeeping/Laundry, Maintenance Director, Director of Social Services, Therapy Manager, Consultant Pharmacist, and Line-Staff Nurse.	5/22/14

and Acute Renal Failure.

Medical record review of the March 2014 MAR revealed the MAR was not signed by the nursing staff administering the medications.

Medical record review of the April 2014 MAR revealed the MAR was not signed by all the nursing staff administering the medications. Further review revealed the MAR contained one nurse's signature.

Interview with Nurse Consultant #1/Acting Director of Nursing, on April 21, 2014, at 11:38 a.m., in the Conference Room confirmed the blood sugar level and the insulin administration when the blood sugar was elevated was to be documented on the Diabetic Medication Administration Record. Further interview confirmed the April 2014, Diabetic Medication Administration Record lacked documentation of blood sugar levels on April 19, 2014, at 9:00 p.m. and on April 21, 2014, before the breakfast meal. Further interview confirmed the insulin should have been administered and the number of units administered was to be documented on April 18 and 19, 2014, at 5:00 p.m. and on April 20, 2014, at 11:00 a.m. due to the elevated accucheck results.

Resident #18 was admitted to the facility on March 13, 2014, with diagnoses including Diabetes Mellitus Type II, and Hypertension.

Medical record review of the March 2014 MAR revealed the MAR was not signed by the nursing staff administering the medications.

Resident #30 was admitted to the facility on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(F 514)	Continued From page 103	(F 514)		

January 31, 2014, with diagnoses including Diabetes Mellitus Type II, Altered Mental State, Cerebral palsy, Quadriplegia, and Hypertension.

Medical record review of the April 2014 MAR revealed the MAR was not signed by all the nursing staff administering the medications. Further review revealed the MAR contained one nurse's signature.

Resident #27 was admitted to the facility on April 14, 2014, with diagnoses including Hypertension, Atrial Fibrillation, Chronic Kidney Disease Stage III, and Altered Mental Status.

Medical record review of a nursing note dated April 17, 2014, at 8:00 a.m., revealed "...IM (intramuscular) Ativan (anti-anxiety medication) obtained from on-call MD (physician) for increased anxiety/agitation..."

Medical record review of the physician telephone orders revealed no order for IM Ativan.

Medical record review of the April 2014 MAR revealed a handwritten entry for Ativan 1 mg (milligram) IM Now for increased anxiety/agitation. Further review of the MAR revealed the Ativan IM had not been administered. Further review of the MAR revealed no documentation addressing the reason for not administering the Ativan.

Medical record review of nursing notes dated April 17, 2014, revealed no documentation addressing the reason for the Ativan IM not being administered.

Review of facility policy, Charting and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

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{F 514}	Continued From page 104	{F 514}		

Documentation, last reviewed on September 2008, revealed "...Physician Orders...Current list of orders must be maintained in the clinical record..."

Review of facility policy, Medication Administration Record: Transcription of Doctor's Orders and Documentation, last reviewed on September 2008, revealed "Documentation procedure...2. If medication is ...omitted...document reasons on reverse side of the MAR..."

Interview with Nurse Consultant #2, on April 22, 2014, at 9:40 a.m., in the conference room,confirmed there was no order for the Ativan IM dated April 17, 2014, in the medical record.

Interview with Licensed Practical Nurse (LPN) #2, on April 22, 2014, at 10:15 a.m., at the 200/300 nursing station, confirmed LPN #2 had written the nursing note dated April 17, 2014, addressing the Ativan IM. Further interview confirmed LPN #2 failed to write an order for the Ativan IM on April 17, 2014. Further interview revealed "...I had full intention today (April 22, 2014) to write the order (for April 17, 2014). I had already written the order dated April 17, 2014, for the IM Ativan prior to Nurse Consultant #2 addressing the lack of a physician order with LPN #2. Further interview revealed Nurse Consultant #2 had instructed LPN #2 to date the nurse's signature April 22, 2014.

Interview with Nurse Consultants #1/Acting Director of Nursing and Nurse Consultant #2,on April 23, 2014, at 12:25 p.m., in the conference room, confirmed the expectation was to write the order for the Ativan IM on April 17, 2014. Further interview confirmed the facility's failure to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

{F 514} Continued From page 105

document the reason for not administering the Ativan IM on April 17, 2014. Further interview confirmed LPN #2 was expected to have dated the IM Ativan order as April 22, 2014, and specified the order was a late entry.

{F 520} 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS
SS=F

A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.

The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.

A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

This REQUIREMENT is not met as evidenced by:
Based on review of Medication Review 3 Month review, review of Timeline of Events, review of

{F 514}

{F 520} F 520

Christian Care Center of Rutherford County believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:

Corrective Actions for Targeted Residents

Physician's Orders are now being followed for Resident #10, #13, #14, #19, #26, #28, #29 and #30.
Resident #1 was a closed chart.
Resident #24 was discharged on 4/23/14.
Resident #3 was transferred to acute care on 3/29/14. Resident #3 returned to the facility on 3/31/14. Resident #3's medications were reconciled from the previous provider accurately on 3/31/14 by the DON. Resident #3 was discharged from the facility on 4/1/14.

Identification of Other Residents with Potential to be Affected

Current residents have a potential to be affected by this practice. On 4/28/14, a Focus Performance Improvement Committee meeting was held by the DON to discuss results and plans from initial annual survey to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	F 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

(F 520) Continued From page 106

New Admission/Readmission Audits, medical record review, review of facility policy, review of facility Performance Improvement Committee Agenda and Minutes, and interview, the facility failed to develop a plan of action related to the failure to follow physician's orders for eleven residents (#1, #3, #10, #13, #14, #19, #24, #26, #28, #29, #30); failure to administer medications as ordered resulting in neglect for two residents (#3, #19); failure to ensure quality of care for eight residents (#1,#3, #10, #13, #14,#19, #24, #29); failure to ensure the facility was free from significant medication errors for two residents (#3, #14); failure to ensure the hospital medication discharge orders and the facility admission medication orders (Physician's Orders) were accurately reconciled for seven residents (#3, #10, #13, #19, #24, #26, #29) of the thirty-one residents reviewed. The facility's failure to ensure the physician's orders were followed, the failure to administer medications as ordered, the failure to ensure the facility was free from significant medication errors, the failure to ensure hospital medication discharge orders and the facility Physician's Orders (facility medication admission orders) were accurately reconciled, and the failure of the facility's Quality Assurance Committe to ensure an effective Performance Improvement program was in place, resulted in Immediate Jeopardy (a situation in the provider's noncompliance with one or more requirements of participation has caused, or was likely to cause, serious injury, harm impairment or death) for three residents (#3, #14, #19) of thirty-one residents reviewed. The systems failure had the potential to place all residents in the facility who received medications in Immediate Jeopardy.

The Administrator, Regional Administrator

(F 520) include failure to follow physician's orders, failure of the facility to be free of significant medication errors, and failure to develop a plan of action to prevent these issues. Committee members present were the Administrator, Director of Nursing, Medical Records Clerk, MDS Coordinator, and the Medical Director and Attending Physicians via conference call. Discussions included follow-up to recent survey such as 100% audit of active residents' admission/re-admission orders from the facility-pharmacy matching the discharge orders from the previous provider, ensuring all pages were faxed to the pharmacy and reconciled correctly onto the MARs, was conducted by the DON and Nurse Consultant beginning on 4/18/14; completed on 4/22/14. The results of these admission/ re-admission order audits and the action taken by the DON and Nurse Consultant are as follows: Orders not transcribed correctly onto the MAR affected nine residents. These residents' medications were reconciled correctly onto the MAR by the Nurse Consultant on 4/22/14. Omission of medication administration doses affected two residents. MD and family notified of errors on 4/22/14 by Nurse Consultant. Nursing education for licensed staff by DON occurred regarding these errors on 4/22/14. Also on 4/25/14, the DON re-wrote clarification orders for all resident-charts cited for this issue by matching current orders to current MARs to ensure physician's orders are followed for accu-checks and sliding scale insulin and that medication reconciliation is correct. The remaining residents' medications were reconciled by the Nursing staff during

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

(F 520) Continued From page 107

Consultant, Assistant Director of Nursing, Nurse Consultant #1/Acting Director of Nursing, Nurse Consultant #2, Nurse Consultant #3, Vice-President of Client Operations, and Medical Director #1 were informed of the Immediate Jeopardy on April 24, 2014, at 10:55 a.m., in the Conference Room.

The Immediate Jeopardy was effective March 14, 2014, and was ongoing.

Substandard Quality of Care was cited under F224-K, F309-K, and F333-L.

An extended survey was conducted on April 24, 2014.

The facility provided an acceptable Allegation of Compliance on May 8, 2014, and a revisit on May 13, 2014, and May 14, 2014, revealed the corrective actions implemented on May 2, 2014, removed the Immediacy of the Jeopardy.

Noncompliance for F-520 continues at a "F" level citation for the facility's monitoring the effectiveness of corrective actions in order to ensure sustained compliance and evaluation of the processes by the Quality Assurance Committee.

The findings included:

Review of the facility's Plan of Correction (facility's own internal corrective action plan), completed by the Director of Nursing (DON) on April 2, 2014, in response to the DON's discovery of the significant medication errors for resident #3 revealed, the facility had became aware of medications which were being omitted from the

(F 520) the MAR change-over procedure due 5/1/14. This MAR change-over was double-checked by the Nurse Consultant on 4/29/14 and 4/30/14 to ensure accurate medication reconciliation onto new MAR.

Systematic Changes

Standing Orders were revised and signed by the Medical Director on 4/28/14. Facility protocol for sliding scale insulin administration was discontinued by the Medical Director on 4/28/14. Per the Medical Director's approval, sliding scale insulin administration will follow the physician's discharge orders from the hospital/previous provider. Pharmacy was notified of this revision for Standing Orders on 4/29/14. These Standing Orders were placed in the residents' charts and in the front of the MARs by the DON on 4/29/14, who instructed each nurse when and how to use these orders and where they could be located; completed on 5/1/14. Any issues of noncompliance with medication reconciliation of admission/re-admissions, accu-check performance/sliding scale administration, drug irregularities, or inadequate medical care will be communicated to the Medical Director by the DON and to the Performance Improvement Committee on the day of discovery of issue to ensure appropriate steps are taken to remedy the problem. Focus of noncompliant issues found during the recent survey will be priority of the Performance Improvement Committee to remedy issues in a timely manner.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

(F 520) Continued From page 108

hospital discharge records when reconciled with the facility's admission medication orders and Medication Records (MARs) sent from the pharmacy. Continued review revealed the April 2, 2014, Plan of Correction was developed by the DON which stated the facility would complete a 100 % (percent) audit of all active residents by conducting a reconciliation with the MARs and the Physician Orders. Continued review revealed the Plan of Correction was to provide education of all Licensed Nursing Staff on the new system to be initiated requiring two nurses to double check the hospital discharge orders with the Physician's Orders and the MARs. Further review revealed the Plan of Correction was for each admission record to be reviewed in morning Stand-up meeting on the "following business day" after a resident's admission or readmission to the facility. Continued review revealed each physician order, after a resident's admission to the facility, was to be verified by nursing administration "...the following business day..." Continued review of the Plan of Correction revealed the plan was ongoing with each new admission and physician order.

Review of Performance Improvement Meeting Minutes, dated April 10, 2014, revealed the DON, Administrator, Assistant Director of Nursing (ADON), Pharmacist #1, Medical Director #2, Medical Director #1, as well as other facility staff attended the April 10, 2014, Performance Improvement meeting (Quality Assurance). Continued review revealed, "...Issue resident admitted, pharmacy only received 3 of the pages...Resolution plan .1. All orders faxed and both nurses' sign and fax confirmation and name of pharmacist who received the fax. 2. When medication arrive 2 nurses will check the POS

(F 520) Monitoring

A Performance Improvement Committee meeting will be held monthly in which the Medical Director and Attending Physicians will take an active role in coordination of medical care at the facility. The Medical Director can communicate to each Attending Physician during this monthly meeting regarding oversight to the extent possible that care is adequate. Each Attending Physician has contact information for easy accessibility to the others – including to the Medical Director. A Performance Improvement Committee meeting will be held monthly for discussion and communication by the DON/ADON of issues found from audit results of New Medication Reconciliation Audits, accu-check performance/sliding scale administration audits, failure to follow physician's orders, failure to be free of significant medication errors and other resident issues that have arisen to ensure there is an effective Performance Improvement Plan in place. A Performance Improvement Committee meeting consisting of the Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Pharmacy Consultant, Quality Assurance Nurse, and MDS Nurses was conducted on 5/22/14 and results of the above audits were found to be in continued compliance. The daily accu-checks/sliding scale insulin administration audits and the daily medication reconciliation audits will continue to be completed daily for three months. The monthly MAR audit for compliance will continue to be conducted daily for three months as a recommendation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 520}	Continued From page 109 (Physician's Orders) and MAR to reconcile with admission orders from previous provider. 3. Pharmacy is currently making changes with their system to alleviate any further problems. Nurses are also being educated with this new process..." Further review of the Performance Improvement Meeting Minutes revealed the facility did not address the results of the New Admission/Readmission Audits which had been completed by the DON which had identified continued problems with medication reconciliation processes. Interview with the DON and Nurse Consultant #1 on April 17, 2014, in the Conference Room, confirmed the audit was completed per the Plan of Correction dated April 2, 2014, of all residents in the facility. Further interview confirmed both the DON and Nurse Consultant #1 participated in Quality Assurance meetings. Continued interview confirmed Nurse Consultant #1 emailed the results of the audit to the DON on April 4, 2014. Further interview confirmed both the DON and Nurse Consultant #1 were aware of the results of the audit which documented resident #19 was receiving medications which had not been ordered on admission, and were aware resident #19 was not receiving other medications which had been ordered. Continued interview confirmed both the DON and the Nurse Consultant #1 failed to follow-up on the audit until informed by the surveyor of the on-going medication errors during the interview on April 17, 2014. Interview with the Administrator on April 21, 2014, at 9:40 a.m., in the Conference Room, confirmed the Administrator was also notified by email on April 4, 2014, of the results of the chart audits.	{F 520}	from the Performance Improvement Committee and will continue to be reviewed monthly by the Performance Improvement Committee for recommendations regarding monitoring frequency, adjustments to monitoring, and/or system changes. The Administrator and DON will follow up on recommendations from the Performance Improvement Committee to assure continued compliance. The Performance Improvement Committee consists of the Administrator, Medical Director, Business Office Manager, Director of Nursing, Assistant Director of Nursing, Human Resources Clerk, Clinical Records Clerk, Marketing/Admissions Director, MDS Coordinator, Assessment Nurse, Director of Activities, Director of Dietary, Director of Housekeeping/ Laundry, Maintenance Director, Director of Social Services, Therapy Manager, Consultant Pharmacist, and Line-Staff Nurse. The facilities governing body will increase the frequency of nurse consultant visits to twice a month for three month. The facilities governing body will also have a nurse consultant present for the Performance Improvement meeting for three months to ensure continued compliance and system monitoring. The facilities governing body is a Management Consulting entity.	5/22/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 520}	Continued From page 110	{F 520}		

Continued interview with the Administrator confirmed the Administrator also failed to follow-up on the results of the audit and was aware the medication errors had been identified. Further interview confirmed no action had been taken by Nursing Administration Staff or the Administrator to address the audit concerns. Further interview confirmed the Administrator had participated in the last Performance Improvement meeting on April 10, 2014, and "...talked about reconciliations..." Continued interview confirmed the Administrator had "...discussions..." with the pharmacy related to the medication errors which had occurred. Further interview confirmed no new plan had been put in place since the original Plan of Correction presented by the DON on April 2, 2014.

Interview with Medical Director #2 on April 21, 2014, at 11:52 a.m., in the Conference Room, revealed "...was at the last Performance Improvement meeting (April 10, 2014)...don't remember specifics...talked about changing processes...and issue with medications...I would expect something to happen...Not sure of specifics...Not aware of what the checks and balances were in place...Not aware of what pharmacy has or had in place to correct issues..."

Interview with Medical Director #3 on April 22, 2014, at 9:30 a.m., in the conference room, revealed "...was not at last Performance Improvement meeting (April 10, 2014)...was aware was working on issue of confusing hospital discharge orders due to multiple sets provided to the facility...The administrator has not as yet approached (Medical Director #3) to address the issue..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 520}	Continued From page 111	{F 520}		

Interview with Pharmacist #1 April 22, at 1:25 p.m., in the Conference Room, confirmed the pharmacist attended the last Performance Improvement meeting on April 10, 2014. Continued interview with Pharmacist #1 confirmed the pharmacist was aware of the medication reconciliation issues, and confirmed was aware of the Plan of Correction processes which had been instituted. Further interview confirmed the pharmacy had instituted an internal process to correct medication reconciliation issues. Continued interview confirmed Pharmacist #1 or Pharmacist #2 were to audit all resident's hospital discharge orders with the Physician's orders the day following a resident's admission to the facility.

Refer to F157-J, F224-K, F281-L, F309-K, F333-L, F425-L, F490-L, F501-L

Validation of the Credible Allegation of Compliance was accomplished on-site on May 13, 2014, and May 14, 2014, through medical record reviews, review of facility documents, and interviews with Nursing and Administrative Staff.

The facility provided evidence of audits of reconciliation of admission/re-admission orders, in-service training for all nursing staff related to physician notification of medication errors, admission/readmission physician order and medication reconciliation, medication omissions, blood glucose monitoring and shift to shift audits of accu-checks and sliding scale insulin, sliding scale insulin orders, and physician standing orders, and the pharmacy procedure for medication orders.

The facility provided documentation of an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF RUTHERFORD COUNTY LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

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{F 520}	Continued From page 112	{F 520}		

emergency Performance Improvement Meeting held on April 28, 2014, to discuss the new admission/readmission medication reconciliation process, pharmacy process, and physician notification process. and provided evidence of establishing a Performance Improvement Committee which will meet monthly for three consecutive months. The medication error audits, admission/readmission orders audits, accu-check performance/sliding scale administration audits will be presented to ensure accurate medication reconciliation procedures are in place

Interviews with Nursing Staff on all shifts May 13-14, 2014, revealed the nursing staff had been In-serviced on the protocol for new admission/readmission medication order reconciliation, pharmacy protocol, medication errors, and physician standing orders.

The facility will remain out of compliance at a Scope and Severity level "F" a deficient practice that constitutes no actual harm with potential for more than minimal harm, that is not Immediate Jeopardy until it provides an acceptable plan of correction and corrective actions are verified onsite.

C/D #33583